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NORTH CAROLINA

Medical Journal

THIS ISSUE: Carolinas' Camp for Diabetic Children. II. Descriptive Features of a Camper Population with Emphasis on Complications, Jay S. Skyler, M.D., George J. Ellis, III, M.D., and Carl H. Bivens, M.D.; Primary Medical Care and Group Practice in North Carolina, John Allcott, M.D., Donald L. Madison, M.D. and Cecil G. Sheps, M.D.; Initial Care for Lacerations of Flexor Tendons of the Hand, Robert B. Winslow, M.D., and A. Griswold Bevin, M.D.

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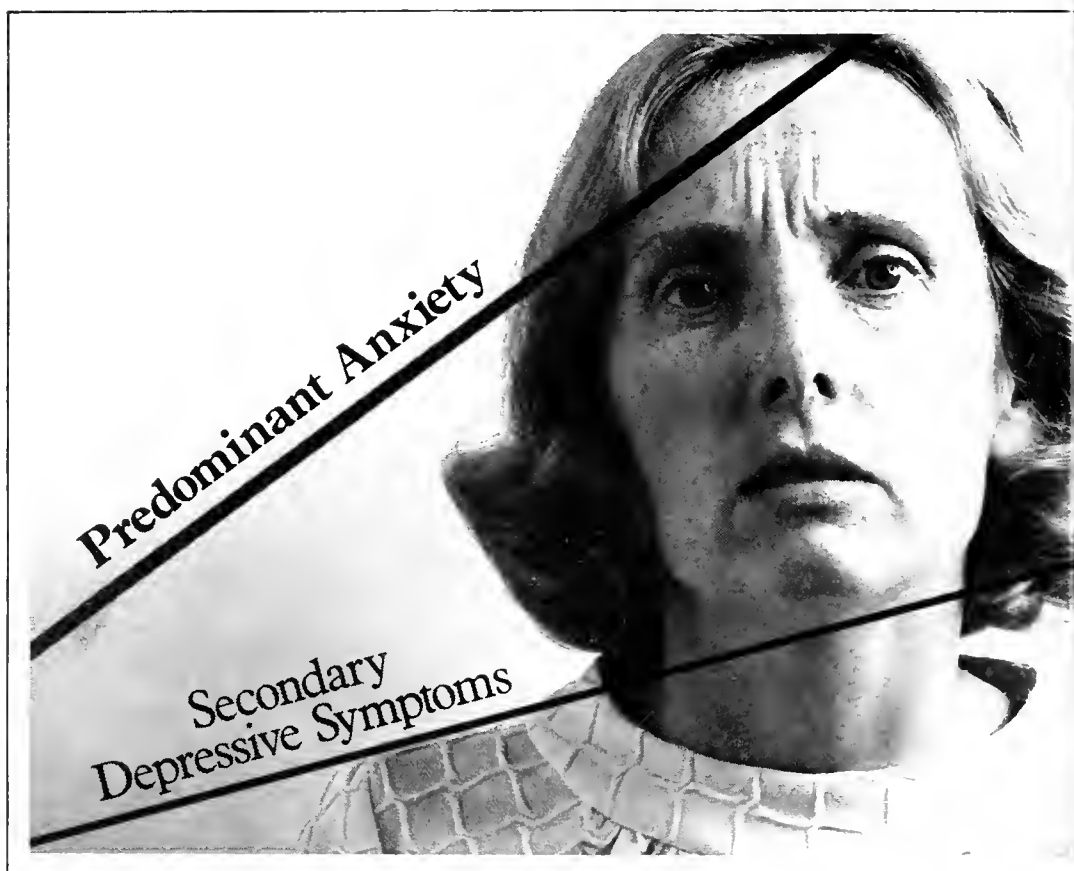


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orders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant

medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

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vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.



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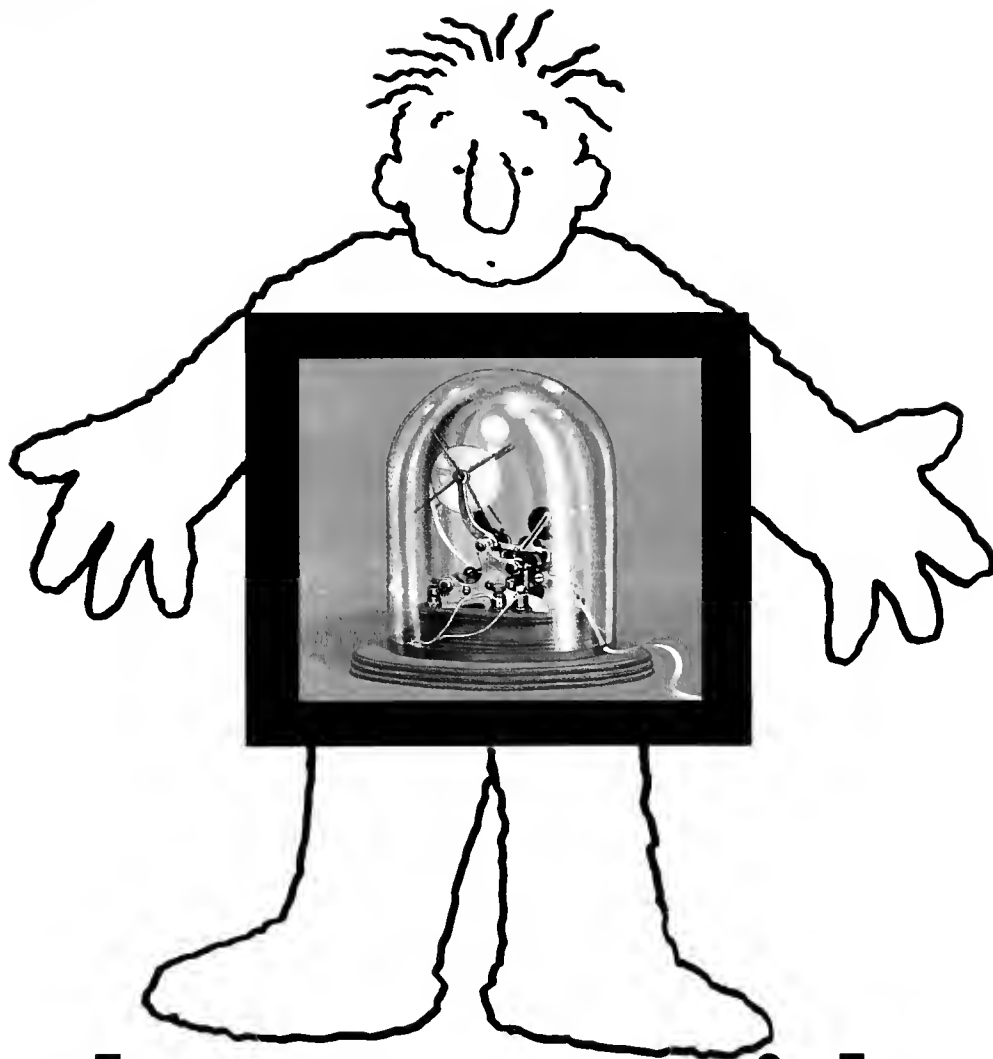
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What's on your patient's face...

may be more important than his chief complaint

Patient P.T.* seen on 3/29/67 shows typical lesions of moderately severe keratoses. Note residual scarring on ridge of nose from previous cryosurgical and electrosurgical procedures.



Patient P.T.* seen on 6/12/67, seven weeks after discontinuation of 5% FU cream. Reaction has subsided. Residual scarring not seen except that due to prior surgery. Inflammation has cleared and face is clear of keratotic lesions.

*Data on file,
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**The lesions on his face
are solar/actinic—
so-called "senile" keratoses...
and they may be premalignant.**

Solar, actinic or senile keratoses

These lesions may be called by several names, but they usually can be identified by the following characteristics. The typical lesion is flat or slightly elevated, of a yellowish or reddish color, papular, dry, rough, adherent and sharply defined. They commonly occur as multiple lesions, chiefly on the exposed portions of the skin.

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Precautions: If applied with fingers, wash hands immediately. Apply with care near eyes, nose and mouth. Lesions failing to respond or recurring should be biopsied.

Adverse Reactions: Local—pain, pruritus, hyperpigmentation and burning at application site most frequent; also dermatitis, scarring, soreness and tenderness. Also reported—insomnia, stomatitis, suppuration, scaling, swelling, irritability, medicinal taste, photosensitivity, lacrimation, leukocytosis, thrombocytopenia, toxic granulation and eosinophilia.

Dosage and Administration: Apply sufficient quantity to cover lesion twice daily with nonmetal applicator or suitable glove. Usual duration of therapy is 2 to 4 weeks.

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Precautions: As with other thyroid preparations, an overdosage of SYNTHROID (sodium levothyroxine) may cause diarrhea or cramps, nervousness, tremors, tachycardia, vomiting and continued weight loss. These effects may begin after four or five days or may not become apparent for one to three weeks. Patients receiving the drug should be observed closely for signs of thyrotoxicosis. If indications of overdosage appear, discontinue medication for 2-6 days, then resume at a lower dosage level. In patients with diabetes mellitus, careful observations should be made for changes in insulin or other antidiabetic drug dosage requirements. If hypothyroidism is accompanied by adrenal insufficiency, such as Addison's Disease (chronic adrenocortical insufficiency), Simmonds's Disease (panhypopituitarism) or Cushing's syndrome (hyperadrenalism), these dysfunctions must be corrected prior to and during SYNTHROID (sodium levothyroxine) administration. The drug

should be administered with caution to patients with cardiovascular disease; development of chest pains or other aggravations of cardiovascular disease requires a reduction in dosage.

Contraindications: Thyrotoxicosis, acute myocardial infarction. **Side effects:** The effects of SYNTHROID (sodium levothyroxine) therapy are in being manifested. Side effects, when they occur, are secondary to increased rates of metabolism: sweating, heart palpitations, or without pain, leg cramps, and weight loss. Diarrhea, vomiting, and nervousness have been observed. Myxedematous patients with heart disease have died from abrupt increase in dosage of thyroid drugs. Careful observation of the patient during the beginning of any thyroid therapy will alert the physician to any toward effects.

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3 T₄ hormone content is controlled by chemical assay.

4 *Synthroid* is assayed chemically; no biologic test is necessary to measure potency.

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dose may be increased to 0.05 mg. after two weeks and to 0.1 mg. at the end of a second two weeks. The daily dose may be further increased at two-month intervals by 0.1 mg. until the optimum maintenance dose is reached (0.1-1.0 mg. daily).

Supplied: Tablets: 0.025 mg., 0.05 mg., 0.1 mg., 0.15 mg., 0.2 mg., 0.3 mg., 0.5 mg., scored and color-coded, in bottles of 100, 500, and 1000. Injection: 500 mcg. lyophilized active ingredient and 10 mg. of Mannitol, U.S.P., in 10 ml. single-dose vial, with 5 ml. vial of Sodium Chloride Injection, U.S.P., as a diluent. SYNTHROID (sodium levothyroxine) for Injection may be administered intravenously utilizing 200-400 mcg. of a solution containing 100 mcg. per ml. If significant improvement is not shown the following day, a repeat injection of 100-200 mcg. may be given.

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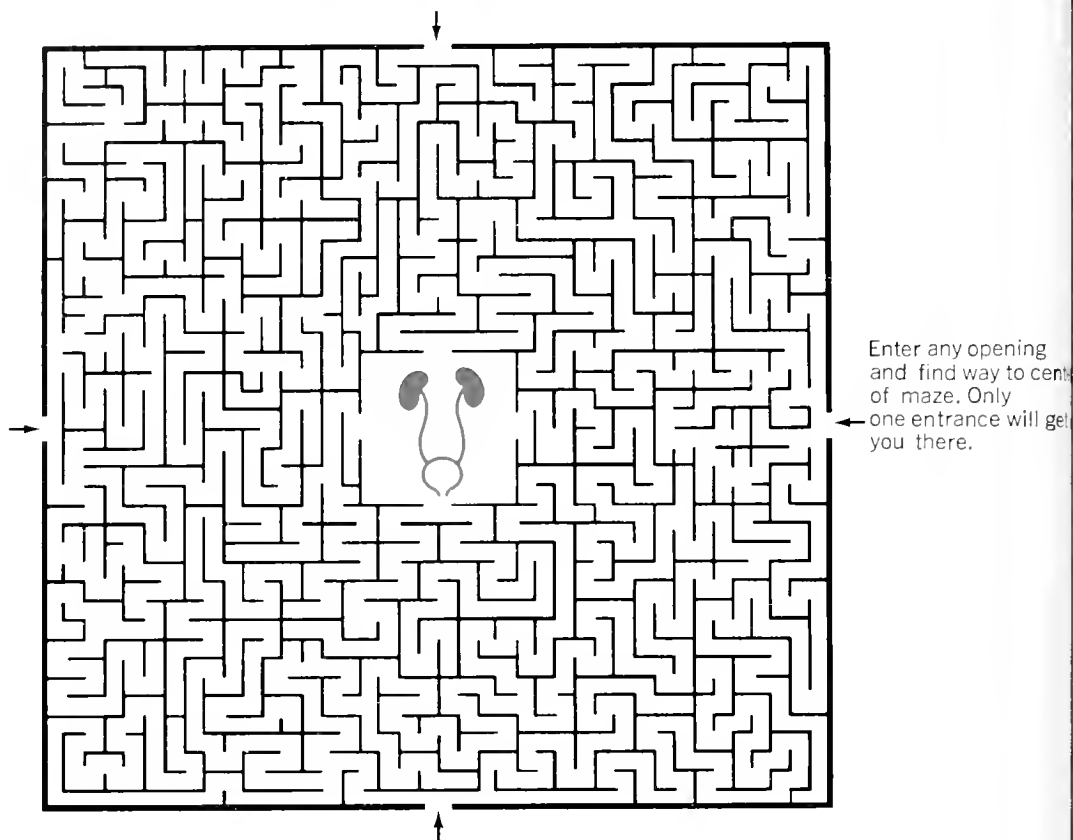
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Basics in the treatment of urinary tract infection

Short-term therapy is no shortcut



The case for adequate length of therapy

In the insidious, common and often stubborn urinary tract infections, duration of therapy is not standardized. Because renal damage in many patients is believed to result from repeated urinary tract infections in childhood, one pediatrician has stated that a rational approach to treatment includes more than a perfunctory prescription of an antibacterial agent.¹

The first 48 hours and after...

To ensure adequate therapy, one expert² proceeds as follows: an initial culture and one after 48 hours. If the antibacterial used has been effective, the urine will be clear of pathogens after 24 to 48 hours. However, urine should be recultured and any persistence of original pathogens indicates that another drug be used. On the other hand, if urine is found to be sterile, the same drug is continued for two weeks. Then urine is recultured starting a week after the last drug dose, and cultures are continued monthly for three months, then every three months for a year, and finally, every four months for several years.²

Another authority³ notes that initial short-term therapy without careful follow-up can lead to trouble, as reflected by the high relapse rate. He treats an initial urinary tract infection with a sulfa drug after taking a urine culture. If *Escherichia coli* is found — and it is in 70 to 80 per cent of cases — he continues full dosage for 21 days. Five to 10 days after cessation of therapy, he recultures and takes a colony count. If urine is sterile, he recultures at three and six months.

Measurement of success

For success in the treatment of urinary tract infection the urine must be kept free of bacteria for prolonged periods until the focus of infection in the tissue has been eradicated.³ This may take months or years when the infection is chronic or persistent. Criteria for successful therapy with a drug are regarded as absence of symptoms and absence of pyuria and bacteriuria.³ One authority defines significant bacteriuria as a count of at least 100,000/ml of the same organism in two consecutive clean-voided urine samples.

The nature of the infection and the length of therapy

Long-term follow-up is essential, a clinician who treats recurrent infections for one to two years points out. Persistent, symptomless bacteriuria usually calls for urologic procedures to find the site of infection, because an underlying abnormality predisposing to urinary tract infection must be detected and corrected — otherwise therapy is futile.⁵ Upper urinary tract infection generally requires longer therapy than infection of the lower urinary tract.

In acute, simple, first infections of a symptomatic type, the pathogens are nearly always *E. coli* or *Proteus mirabilis*.⁵

References: 1. Normand, I. C. S.: *Practitioner*, 204:91, 1970. 2. K. E. H.: *Hosp. Med.*, 4:73, 1968. 3. Lampe, W. T., II: *J. Am. Geriatr. Soc.*, 16:798, 1968. 4. Petersdorf, R. G., and Turck, M.: *GP*, 32:(2) 130, 1965. 5. Benner, E. J.: *Med. Times*, 98:(2) 95, 1970.



The case for Gantanol® (sulfamethoxazole)

is susceptible organisms most often indicated

Gantanol® (sulfamethoxazole) is effective against highly susceptible strains of *E. coli* and *Proteus mirabilis* as well as *Klebsiella-Aerobacter*, *Staphylococcus aureus* and frequently, *Proteus vulgaris*—pathogens apt to be in the mixed bacterial flora of recurrent and chronic cystitis and/or pyelonephritis.

Opt antibacterial blood/urine levels

After the initial 2-Gm adult dose, therapeutic blood and urine levels are usually reached in from 2 to 3 hours and then maintained with either of the two dosage forms of Gantanol—tablets or suspension. And, Gantanol dosage means up to 12 hours of antibacterial activity, obviating the patient's having to disturb his sleep for medication. More severe infections may require higher dosage.

Effective in certain nonobstructed acute and recurrent urinary tract infections. In nonobstructed chronic and recurrent cystitis or pyelonephritis develops more commonly in the elderly and debilitated, and response to Gantanol (sulfamethoxazole) is highly satisfactory. The usual precautions in sulfonamide therapy should be observed, including maintenance of adequate fluid intake, frequent c.b.c.'s and urinalyses with microscopic examination.

Make the therapy suit the infection

In most urinary tract infections the *b.i.d.* schedule will usually suffice, but therapy must be maintained long enough to ensure eradication of pathogens. Mounting evidence in current medical literature suggests a minimum of 14 days of continuous therapy.* Adequate treatment for a sufficient time may also help prevent possible kidney damage. Gantanol is generally well tolerated with relative freedom from complications. The most common side effects include nausea, vomiting and diarrhea. Prescribe Gantanol tablets or the pleasant-tasting suspension.

*Data on file, Hoffmann-La Roche Inc., Nutley, N.J.

In nonobstructed cystitis due to susceptible organisms

Gantanol[®] B.I.D. (sulfamethoxazole)

Basic Therapy



Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, N.J. 07110

Please see following page for summary of product information.

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Acute, recurrent or chronic nonobstructed urinary tract infections (primarily pyelonephritis, pyelitis and cystitis) due to susceptible organisms. **Note:** Carefully coordinate *in vitro* sulfonamide sensitivity tests with bacteriologic and clinical response; add aminobenzoic acid to follow-up culture media. The increasing frequency of resistant organisms limits the usefulness of antibacterials including sulfonamides, especially in chronic or recurrent urinary tract infections. Measure sulfonamide blood levels as variations may occur; 20 mg/100 ml should be maximum total level.

Contraindications: Sulfonamide hypersensitivity; pregnancy at term and during nursing period; infants less than two months of age.

Warnings: Safety during pregnancy has not been established. Sulfonamides should not be used for group A beta-hemolytic streptococcal infections and will not eradicate or prevent sequelae (rheumatic fever, glomerulonephritis) of such infections. Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been reported and early clinical signs (sore throat, fever, pallor, purpura or

jaundice) may indicate serious blood disorders. Frequent CBC and urinalysis with microscopic examination are recommended during sulfonamide therapy. Insufficient data on children under six with chronic renal disease.

Precautions: Use cautiously in patients with impaired renal or hepatic function, severe allergy, bronchial asthma; in glucose-6-phosphate dehydrogenase-deficient individuals in whom dose-related hemolysis may occur. Maintain adequate fluid intake to prevent crystalluria and stone formation.

Adverse Reactions: *Blood dyscrasias* (agranulocytosis, aplastic anemia, thrombocytopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia); *allergic reactions* (erythema multiforme, skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis); *gastrointestinal reactions* (nausea, emesis, abdominal pains, hepatitis, diarrhea, anorexia, pancreatitis and stomatitis); *CNS reactions* (headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo and insomnia); *miscellaneous reactions* (drug fever, chills, toxic nephrosis with

oliguria and anuria, periarteritis nodosa and L.E. phenomenon). Due to certain chemical similarities with some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia as well as thyroid malignancies in rats following long-term administration. Cross-sensitivity with these agents may exist.

Dosage: Systemic sulfonamides contraindicated in infants under 2 months of age (except adjunctively with pyrimethamine in congenital toxoplasmosis).

Usual adult dosage: 2 Gm (4 tablets) initially, then 1 Gm *b.i.d.* or *t.i.d.* depending on severity of infection.

Usual child's dosage: 0.5 Gm (1 or 2 tablets) / 20 lbs of body weight initially then 0.25 Gm / 20 lbs *b.i.d.* Maximum dose should not exceed 75 mg/kg / 24 hrs.

Supplied: Tablets, 0.5 Gm sulfamethoxazole; Suspension, 0.5 Gm sulfamethoxazole / teaspoonful.



Roche Laboratories
Division of Hoffmann-La Roche
Nutley, N.J. 07110

Rx
Gantanol
Tabs #58
Sig: 4 tabs stat
then 2 tabs B.I.D.
until finished

In nonobstructed cystitis due to susceptible organisms
Gantanol[®] (sulfamethoxazole) B.I.D.
Basic Therapy



PRESIDENT'S NEWSLETTER

MEDICAL SOCIETY OF THE STATE OF NORTH CAROLINA

No. 8

January 9, 1974

1974 may be a Happy New Year and we wish the same to all of you. We can be more certain, what with energy crises, political turmoil, continuing inflation, and many medical bills in our upcoming state legislation, that it is sure going to be a hectic New Year in the practice of medicine.

At the Clinical Convention of the AMA at the Disneyland Hotel in California, as usual, your North Carolina Delegation actively covered and participated in the deliberation for your benefit. The biggest consumer of time, interest, and change in AMA policy was --you guess it-- PSRO. From all over the country and after living with the potentials of this law, the groundswell of opinion was loud and clear. The AMA and all its members should work for its repeal. In a very well thought out statement which passed the House of Delegates, this goal was expressed. In spite of this very worthy goal, it was equally clear, from a point of view of practical politics, that the chances of repeal in the Congress are very slim. This should in no way dim or diminish our zeal in trying to get it repealed. We therefore strongly urge you to write your congressman in favor of the bill introduced by Congressman Rarick of Louisiana for repeal of PSRO. Please stress, however, that we in organized medicine are still strongly and constantly pushing our efforts for "peer review" to keep our own house clean but that this PSRO bureaucracy is not the way.

One of the constructive suggestions is now quoted from the AMA amendment to report EE paragraph number 3:

"That the Association suggests that each hospital medical staff, working with the local medical society, continue to develop its own peer review, based upon principles of sound medical practice and documentable objective criteria, so as to certify that objective review of quality and utilization does take place; to make these review procedures sufficiently strong as to be unassailable by any outside party or parties; and that the local and state medical societies take all legal steps to resist the intrusion of any third party into the practice of medicine."

Meanwhile the federal juggernaut roles on, and on December 20th published in the Federal Register were the long awaited PSRO geographical boundaries. To have verbal description, the PSRO geographical boundaries were outlined in the December 24, 1973, issue of the American Medical News, revealing the Secretary of HEW's decision for the four PSRO's in North Carolina. In accordance with the action of the House of Delegates and the wishes of the Board of Directors of the Peer Review Foundation, an objection to these designations will be filed before January 19, 1974, and our request for a statewide designation will be renewed. The presidents of each county society have been asked to send to headquarters office a letter supporting our protest and renewed request for a statewide PSRO designation, which request I sincerely hope will have a 100% response.

A second most crucial concern of the AMA is its ongoing fight with the Cost of Living Council to do away with the Phase IV discrimination against the private practicing physician. The AMA has filed an official protest in the form of a petition with the Cost of Living Council. This is the first step and is a prerequisite to the filing of legal action by the AMA (or any other Medical Society) on behalf of the medical profession against the Cost of Living Council.

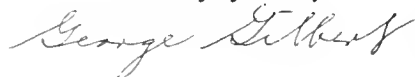
Mentioned in previous "Newsletters" has been our deep concern over the surprisingly widespread practice of physicians' employees, with their employers sanction, making the medical decision for prescription refills and even new prescriptions. This very sloppy and shady practice has brought about a most productive meeting of your State Society Pharmacy Committee along with officers of the State Pharmaceutical Association. As a result of this meeting, the joint effort is being launched by our two organizations and we implore your cooperation. Each pharmacist in the state will receive enough copies of a form which has been compiled, along with a covering letter from me in behalf of the Medical Society. The pharmacist by this device will be urged to send one form to his regular doctor prescribers. Each of you will be receiving these forms which will tell your druggist a number of things about your office so as to upgrade not only the quality of prescription writing but also make it possible for the pharmacist to follow your personal prescription routine. Perhaps most important is the blank for you to sign your name exactly as you do on a prescription. Prescription forging and theft of prescription pads is becoming alarmingly widespread.

One more plea. We are cooperating through an ad hoc committee with the State Department of Mental Health and have formed an ad hoc committee. The goal of this ad hoc committee is an effort to upgrade the quality and financial return for full and part-time physicians in our statewide mental health institutions. This includes not only psychiatrists but also surgeons, pediatricians, internists, family physicians. In behalf of this committee, we want to know how many of you would be willing to work on a part-time basis in these institutions and how much money do you feel you should receive for a day's service? Put another way, how much compensation would make such an effort attractive to you? I urge all of you who may be interested to write the Chairman of this ad hoc committee who is also Chairman of our State Society Mental Health Committee, Dr. Philip Nelson, Medical Pavilion, Greenville, N. C. 27834.

To the many members of the Society who have written the Governor concerning the appointment of a Chiropractor to the Board of the North Carolina Division of Health Services (formerly State Board of Health), please accept my thanks for doing so and for your interest and participation in affairs of concern to the Society.

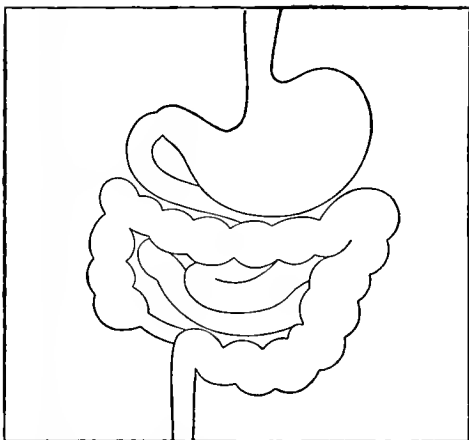
Happy New Year!

Sincerely yours,



George G. Gilbert, M.D.
President

in "Gasspastic" conditions



The GI tract in spasm is commonly a "gas trap."

Sidonna® is formulated to release entrapped gas, as well as to provide antispasmodic/sedative effects.

In addition to the traditional combination of belladonna alkaloids and butabarbital (warning: may be habit forming.), Sidonna contains simethicone—a non-systemic defoaming agent that "lyses" gas bubbles on contact.

Sidonna has the ability to relieve GI spasm, pain **and gas** in the irritable bowel syndrome, spastic colon, pylorospasm, gastroenteritis, gas-

tritis, nausea, nervous indigestion, or gastric and duodenal ulcer.

Sidonna can calm GI spasm...control anxiety...and release entrapped GI gas from the system.

Sidonna can do more for your "gasspastic" patient. Try him on 1 or 2 tablets before meals and at bedtime.

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Each scored tablet contains: Specially activated simethicone 25 mg.; hyoscyamine sulfate 0.1037 mg., atropine sulfate 0.0194 mg., hyoscine hydrobromide 0.0065 mg. (equivalent to belladonna alkaloids [as bases] 0.1049 mg.) and butabarbital sodium N.F. 16 mg. (Warning: May be habit forming.)

can do more

Contraindications: Anticholinergics should not be used in patients with glaucoma, known prostatic hypertrophy, or pyloric obstruction. Urinary retention may indicate the presence of prostatic hypertrophy. If it occurs, the dose should be reduced or the drug withdrawn. Also contraindicated in patients with known hypersensitivity to one of the components.

Side Effects: Dryness of the mouth, blurred vision, dysuria, skin rash, constipation or drowsiness may occur.

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alities are used. The services consist of individual, couple, group and family psychotherapies; sexual and marriage counseling; pastoral counseling; vocational guidance and rehabilitation; alcohol and drug counseling; psychological testing, chemotherapy, electrotherapy and other somatic therapy services.



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Our skin—the human integument—covers us, defines us, protects us. But skin is subject to cuts, burns, abrasions. And infections. Neosporin Ointment fights infection by providing broad antibacterial action against susceptible skin invaders. It contains antibiotics that are rarely used systemically, reducing the risk of sensitization.



INDICATIONS: Therapeutically, used as an adjunct to appropriate systemic therapy for topical infections, primary or secondary, due to susceptible organisms, as in:

- infected burns, skin grafts, surgical incisions, otitis externa
- primary pyodermas (impetigo, ecthyma, sycosis vulgaris, paronychia)
- secondarily infected dermatoses (eczema, herpes, and seborrheic dermatitis)
- traumatic lesions, inflamed or suppurating as a result of bacterial infection.

Prophylactically, the ointment may be used to prevent bacterial contamination in burns, skin grafts, incisions, and other clean lesions. For abrasions, minor cuts and wounds accidentally incurred, its use may prevent the development of infection and permit wound healing.

CONTRAINDICATIONS: Not for use in the external ear canal if the eardrum is perforated. This product is contraindicated in those individuals who have shown hypersensitivity to any of the components.

PRECAUTION: As with other antibiotic preparations, prolonged use may result in overgrowth of nonsusceptible organisms and/or fungi. Appropriate measures should be taken if this occurs. Articles in the current medical literature indicate an increase in the prevalence of persons allergic to neomycin. The possibility of such a reaction should be borne in mind.

Complete literature available on request from Professional Services Dept. PML.

NEOSPORIN[®] Ointment

POLYMYXIN B-BACITRACIN-NEOMYCIN)

Each gram contains: Aerosporin[®] brand Polymyxin B Sulfate 5,000 units; zinc bacitracin 400 units; neomycin sulfate 5 mg. (equivalent to 3.5 mg. neomycin base); special white petrolatum q.s. In tubes of 1 oz. and ½ oz. and ¼ oz. (approx.) foil packets.



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More than sleep

your choice of sleep medication
is wisely based on more than
sleep-inducing potential

sleep with relative safety

Chronic tolerance studies have confirmed the relative safety of Dalmane (flurazepam HCl); no depression of cardiac or respiratory function was noted in patients administered recommended or higher doses for as long as 90 consecutive nights.

In most instances when adverse reactions were reported, they were mild, infrequent and seldom required discontinuance of therapy. Morning "hang-over" with Dalmane has been relatively infrequent. Drowsiness, lightheadedness and the like have been the side effects noted most frequently, particularly in the elderly and debilitated. (An initial dose of Dalmane 15 mg should be prescribed for these patients.)

sleep for 7 to 8 hours without need to repeat dosage

No sleep medication has been as rigorously evaluated in the sleep research laboratory as Dalmane. Insomnia patients given one 30-mg capsule of Dalmane at bedtime, on average: fell asleep within 17 minutes, had fewer time awakenings, spent less time awake after sleep onset, and slept for 7 to 8 hours with no need to repeat dosage during the night.

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Dalmane (flurazepam HCl) is a distinctive sleep medication—a benzodiazepine specifically indicated for insomnia. It is not a barbiturate or methaqualone, nor is it related chemically to any other hypnotic.

When your evaluation of insomnia indicates the need for a sleep medication, consider Dalmane—a single entity nonnarcotic, non-habit-forming agent proved effective and relatively safe for relief of insomnia.

Dalmane has been shown to be consistently effective even during consecutive nights of administration, with no need to increase dosage.

DALMANE[®]

(flurazepam HCl)

When restful sleep is indicated

One 30-mg capsule h.s. —usual adult dosage
(15 mg may suffice in some patients).

One 15-mg capsule h.s. —initial dosage for elderly or debilitated patients.

Before prescribing Dalmane (flurazepam HCl), please consult Complete Product Information, a summary of which follows:

Indications: Effective in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening, in patients with recurring insomnia or poor sleeping habits, and in acute or chronic medical situations requiring restful sleep. Since insomnia is often transient and intermittent, prolonged administration is generally not necessary or recommended.

Contraindications: Known hypersensitivity to flurazepam HCl.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. Caution against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Use in women who are or may become pregnant only when potential benefits have been weighed against possible hazards. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage.

Precautions: In elderly and debilitated, initial dosage should be limited to 15 mg to preclude oversedation, dizziness and/or ataxia. If combined with other drugs having hypnotic or CNS-depressant effects, consider potential additive effects. Employ usual precautions in patients who are severely depressed, or with latent depression or suicidal tendencies. Periodic blood counts and liver and kidney function tests are advised during repeated therapy. Observe usual precautions in presence of impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdose, have been reported. Also reported were headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins and alkaline phosphatase. Paradoxical reactions, e.g., excitement, stimulation and hyperactivity, have also been reported in rare instances.

Dosage: Individualize for maximum beneficial effect. *Adults:* 30 mg usual dosage, 15 mg may suffice in some patients. *Elderly or debilitated patients:* 15 mg initially until response is determined.

Supplied: Capsules containing 15 mg or 30 mg flurazepam HCl.



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*The
Weight of
Professional
Opinion*

It's time for action to defend the law and regulations that protect your patients against drug substitution.

**These professional and trade organizations are united
in supporting antisubstitution statutes and regulation**

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The Executive Board of the
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The American College of Allergists

The Executive Committee of the
American College of Obstetricians
and Gynecologists

The Board of Regents of the
American College of Physicians

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American Dental Association

The Board of Trustees of the
American Medical Association

The American Psychiatric Association

The Executive Committee of the
National Association of Retail
Druggists

The Board of Directors of the
Pharmaceutical Manufacturers
Association

The National Wholesale Druggists'
Association

Statement on Antisubstitution Laws and Regulations

The purpose of this statement is to gain the support of the participating organizations for the laws, regulations and professional traditions which prohibit the unauthorized substitution of drug products.

Traditionally, physicians, dentists and pharmacists have worked cooperatively to serve the best interests of patients. Productive cooperation has been achieved through mutual respect as well as a common understanding for the ideals of public service. This mutual respect has been maintained, in part, by joint support of laws and regulations which prohibit the unauthorized substitution and encourage joint decision and selection of the best drug product of supply of drug products. The basic principles of medical, dental and pharmacy practice are thus maintained and preserved in the interest of patient welfare.

The antisubstitution laws have obstructed enhancement of the professional status of pharmacy any more than they have in and of themselves guaranteed absolute protection from unsafe drugs, or freed physicians, dentists and pharmacists from their responsibilities to patients. In fact, however, such laws and regulations encourage interprofessional communications regarding drug product selection and assure each profession the opportunity to use fully its expertise in drug selection to the advantage of patients.

Physicians and dentists should be encouraged to increase the frequency and clarity of their contacts with pharmacists in selection of quality drug products, recognizing that

economies to patients can be improved through such communication, taking into account the patients' needs. The pharmacist's knowledge of the chemical characteristics of drugs, their mode of action, toxic properties and other characteristics that assist in making drug selection decisions should be utilized to the fullest extent practicable by physicians and dentists in serving their patients.

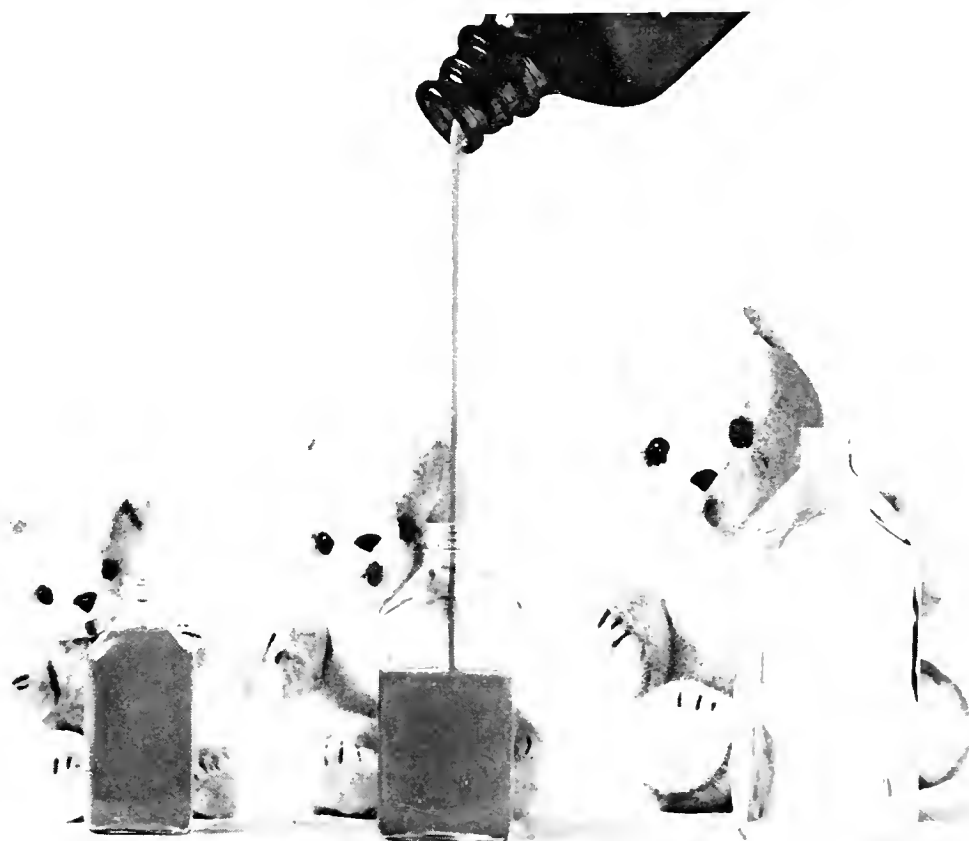
Since drug product selection entails knowledge derived from clinical experience, the physician's and dentist's roles in product selection remain primary and do not permit delegation of decisions requiring medical and dental judgments. A broader role in therapy will evolve for pharmacists as improved understanding and cooperation among the professions continue to grow.

There has been no evidence that there are convincing reasons to modify or repeal existing laws and regulations prohibiting the unauthorized substitution of another drug product for the one specified by a prescriber. It is our belief that such laws and regulations merit the joint support of the medical, dental and pharmaceutical professions and the pharmaceutical industry.

Add your opinion to the weight of other professionals and send it to your state assemblyman or legislator.

*Pharmaceutical Manufacturers Association
1155 Fifteenth Street, N.W., Washington, D. C. 20005*





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Carolinas' Camp for Diabetic Children

II. Descriptive Features of a Camper Population With Emphasis on Complications

Jay S. Skyler, M.D., George J. Ellis, III, M.D., and Carl H. Bivens, M.D.

In our companion paper, we described the organization, operation, and objectives of Carolinas' Camp for Diabetic Children that evolved over our first five years' experience. Access to a large number of children with diabetes mellitus allowed us to make observations about the spectrum of the illness. This paper describes some of these observations about the camper population and the medical problems occurring during one camp session. Our observations, which show that there is a significant incidence of complications of diabetes in these children, may have implications relevant to the large group of patients with juvenile-onset diabetes living in the Carolinas. Thus, these findings are important for all physicians who care for patients with diabetes.

POPULATION

One-hundred thirteen campers and junior counselors with diabetes mellitus attending camp during the 1972 season represent the study population. There were 49 boys and 64 girls, their ages ranging from 7 to 18 years (mean, 11.5; median, 11) (Table 1). Eighty-seven (78.8 per cent) had known positive family histories of diabetes mellitus. The duration of diabetes varied from newly discovered to 11 years with a mean of 3.9 years (Table 2). Eleven had diabetes eight years or longer. The mean age at onset of diabetes was 7.5 years with a range of 1 to 16 years (Table 3).

METHODS

Our defined data base, in addition to a questionnaire answered by parents (available on request), included a limited physical examination (Figure 1). Campers with questionable retinal disease and all campers with duration of diabetes eight years or longer had fundus photographs taken, through dilated pupils, using a hand-held Kowa RC fundus camera. Neuropathy was evaluated by determining, in tripli-

Table 1

Age and Sex Distribution of Campers and Junior Counselors with Diabetes

Age (years)	7	8	9	10	11	12	13	14	15	16	17	18
Boys	1	6	8	6	9	3	5	4	5	2	0	0
Girls	0	8	8	4	7	18	5	5	6	1	1	1
Total	1	14	16	10	16	21	10	9	11	3	1	1

Table 2

Duration of Diabetes in Campers and Junior Counselors

Duration (years)	<1	1	2	3	4	5	6	7	8	9	10	11
Number of individuals	5	14	19	16	15	17	10	6	6	1	2	2

Table 3

Age of Onset of Diabetes in Campers and Junior Counselors

Age at onset (years)	<1	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
Number of individuals	0	2	2	6	7	14	9	20	11	14	7	13	2	2	3	0	1

From the Departments of Medicine and Community Health Science, University Medical Center, Durham, North Carolina, and Carolinas' Camp for Diabetic Children, Pisgah Forest, North Carolina.

CCDC Physical Examination Form

CAMPER _____ Date _____

Height _____ Weight _____ BP _____ R/L Arm _____

Skin: Lipatrophy Lipohypertrophy Other changes Normal
Sites: _____
Description: _____

HEENT: Eyes: EOM: Full No Pupils: React No
Fundus: Discs: Sharp No Macula: Clear No
Hemorrhages Exudates Microaneurysms IRMA
Other: _____

Ears: Drums Clear No Not visualized
Pharynx: Clear Injected
Thyroid: Normal Enlarged description _____
Nodes: No Yes Site/description _____

CHEST: Clear No Description _____

CARDIAC: Gallop: No S₄ S₃ Click
Murmur: No Systolic Diastolic grade ____/vi
location _____
Description _____ Supine Sitting

ABDOMEN: Masses: No Yes Location _____
Organomegaly: No Yes Location _____
Other: _____

EXTREMITIES: Normal Abnormal How? _____

NEUROLOGIC: Ankle jerks: Right—Intact No
Left—Intact No
Vibration: Right great toe—Intact No
Left great toe—Intact No
Other: _____

Examiner _____

Figure 1

cate, the vibratory perception threshold of both index fingers and both great toes, using a Model PVD Bio-Thesimeter (Bio-Medical Instrument Company, Newburg, Ohio), and by measuring Achilles reflex time (interval between time of stimulus and time of half-relaxation) using a Burdick FM-1 Photomotograph. Height and weight percentiles were determined using standard anthropometric charts.²

Data on insulin administration and urine testing were derived from questionnaires answered by campers' parents the first day of camp and from staff observations during camp.

Data on camp illness and hypoglycemic symptoms were obtained from camp medical records. When a hypoglycemic reaction was treated, a card indicating the symptoms and treatment was completed. Some of the reactions were documented using Dextrostix (Ames Company) read with an Ames Reflectometer. All other reactions were considered hypoglycemic if the symptoms were reversed after glucose feeding, or in two episodes, after glucagon injection.

Fasting samples for blood lipids were collected from each camper one morning during the middle of the camp period. Serum was separated and frozen for later analysis of cholesterol and triglyceride.

RESULTS

Nutrition and growth

Eight campers (five girls and three boys) were obese, and none was underweight. Nine boys (18 percent) and three girls (5 percent) ranked below the third percentile in height. The distribution of heights is summarized in Table 4.

Complications

No camper had an elevated blood pressure or absent Achilles reflex. All Achilles reflex times were normal, with the range being 213 to 380 msec, mean 289. Four patients had high vibratory perception thresholds in at least three of the digits tested. Ten others had high thresholds in one or two of the digits tested. Table 5 summarizes the skin and eye problems found in the camper population. All campers with cataracts had visual impairment.

Cholesterol and triglyceride determinations

Cholesterol levels ranged from 110 to 327 mg/dl with a mean of 196. Nineteen patients had values greater than 230, the upper range of normal for this age group, according to Fredrickson.³ Triglyceride levels ranged from 33 to 240 mg/dl with a mean of 72. Three patients had values greater than 140, the upper range of normal in this age group.³

Table 4
Distribution of Heights

Percentile	Girls	Boys	Total
<3	3	9	12
3-10	7	3	10
10-25	11	6	17
15-50	15	10	25
50-75	17	10	27
75-90	7	8	15
90-97	3	2	5
>97	1	1	2

Table 5
Skin Problems in Campers with Diabetes

Lipodystrophy	
Lipatrophy only	24
Lipohypertrophy only	16
Both lipatrophy and lipodystrophy	3
No lipodystrophy	
Necrobiosis lipoidica diabetorum	
Pretibial patches	

Eye Problems in Campers with Diabetes

Diabetic retinopathy	
Microaneurysms, intraretinal microvascular abnormalities	3
Hemorrhages	1
Exudates	0
Proliferative changes	0
Cataracts	
Ptosis	
Retinal pigment spots	

Table 6
Insulin Administration and Urine Testing

	Draw Insulin		Administer Insulin		Check Urine	
	Pre-Camp	End of Camp	Pre-Camp	End of Camp	Pre-Camp	End of Camp
done alone	64	111	53	107	90	112
done with help	11	2	11	5	10	1
not done/unsucessful	38	0	49	1	13	0

Table 7
Number of Hypoglycemic Episodes per Camper*

Number of reactions	0	1	2	3	4	5	6	7	8	9	13
Number of campers	39	27	22	11	4	2	2	1	2	1	1

*One camper was excluded from data because of multiple atypical "reactions" with repeatedly normal or high blood glucose.

Insulin administration and urine testing

Prior to admission to camp, 101 of the 113 campers used disposable syringes and needles, nine used reusable syringes with disposable needles, and three used reusable syringes with reusable needles.

Table 6 summarizes the progress campers made during the camp session in learning to draw and measure insulin, to administer their insulin, and to test for urine for glucose. All campers listed as performing these tasks "alone" at the end of camp demonstrated to the satisfaction of the medical staff that they were using the proper techniques.

Hypoglycemia

There were 187 episodes of hypoglycemia in 73 campers. Forty-six individuals had more than one episode of hypoglycemia (Table 7). Thirty-four of the 114 repeat episodes (as well as four initial episodes) were documented by Dextrostix.

Hypoglycemic reactions were characterized by various combinations of symptoms (Table 8), with 14 of the episodes having a single symptom. Weakness was the most common symptom. Most campers who had more than one reaction also had a recurring group of symptoms, although there was not variability of the symptom complex from camper to camper. The exception to these generalizations usually was seen when a camper had a reaction or reactions at night in which he was unresponsive to light and/or was aroused with difficulty.

Other camp illness

Campers had a total of 201 medical problems (Table 9), excluding hypoglycemia, of which some required multiple infirmary visits. The most severe problems were two fractures. Although there were four instances of severe hyperglycemia, no campers had frank ketoacidosis.

DISCUSSION

The population of campers probably constitutes a representative sample of young juvenile diabetics in the Carolinas. Of interest are several findings. For the group of boys in this sample the high percentage (18.4 percent) with heights below the third percent-

Table 8
Incidence of Hypoglycemic Symptoms (187 episodes)

Symptom	Number of Occurrences
Weakness	124
Trembling	86
Hunger	72
Sweating	51
Headache	30
Pallor	27
Crying/ moaning	27
Tachycardia	21
Dizziness	19
Abdominal pain	18
Inability to arouse	16
Unresponsiveness to light	12
Belligerence/resistiveness/uncooperativeness	12
Drowsiness	10
Resistance to food	9
Diplopia	6
"Nervousness"	6
Disorientation	4
Incoherence	4
Unconsciousness	2
Chest pain	2
Thirst	2
Homesickness	2
Hypothermia (documented)	2
Cold, clammy appearance	2
Irritability	1
Passivity/quietness	1
Hiccups	1
Fasciculations	1
Nightmare	1

Table 9
Camp Illness (excluding hypoglycemia)

Illness	Number of Incidences
Minor injuries (bruises, cuts, blisters, splinters)	62
Sore throats	23
Sprains, strains, muscle soreness	21
Bee stings and insect bites	16
Stomach ache	15
Skin problems	14
Poison ivy/oak	7
Rash	6
Sunburn	1
Headache	12
Earache	11
Homesickness	7
Colds, nasal stuffiness	5
Hyperglycemia	4
Anorexia, nausea, vomiting (not related to diabetic control)	4
Anorexia	2
Nausea	2
Vomiting	1
Eye Problems	4
Conjunctivitis	2
Sty	2
Fractures	2
Toothache	1
Total	201

tile suggests a significant incidence of growth retardation. Since insulin is necessary for protein synthesis, and thus for growth, it would not be surprising to see growth retardation in patients who continually received inadequate amounts of insulin. Unfortunately, we have no data on the long-term degree of diabetic control in our population and can offer no explanation for the sex difference in growth retardation.

We were struck by the number of campers who already demonstrated diabetic complications and lipid abnormalities. Two of the three patients with evidence of retinopathy also had elevated triglycerides, and one had elevated cholesterol as well. Four of the five campers with cataracts also had elevated cholesterol levels, and two had associated neuropathy; all five had some history of very poor control, observed especially during the period immediately before their admission to camp. Cataracts are to be expected if the mechanism of their production in juvenile diabetics is related to hyperglycemia and to subsequent increased activity of aldose reductase within the lens. The resulting accumulation of sorbitol (a nondiffusible sugar alcohol) would cause osmotic changes and eventuate in degenerative changes including cataract formation.⁴ There is some evidence that neuropathy, as well, may be related to this mechanism.⁵

With the evidence that a large number of campers were able to assume responsibility for their own insulin administration and urine testing, we think that primary physicians should be encouraged to develop such capabilities in diabetic patients of all ages. Because many campers, upon returning home, apparently revert to previous habits of permitting elders to administer insulin and/or to check urine, the education process must include relatives as well as patients. Since the children can learn the procedures during a two-week exposure, with encouragement from physicians and parents it should be possible for them to continue to exercise their new skills at home. Assumption of such responsibility is especially important for the child's maturation process and for the fostering of independence and self-discipline. Each

person with diabetes should realize that it is his condition; its course in large part will depend on the rigor with which he applies himself to its management.

Hypoglycemia is quite common at camp, presumably because of the increased activity and freedom from psychological stress. The large number of different symptoms and the varying presentations indicate that physician and patient must be keenly alert to hypoglycemia, especially in a setting (e.g., increased activity) where it is more likely to occur. The other camp illnesses, except for hyperglycemia, might be expected at any summer camp.

SUMMARY

The data indicate to us that insulin deficiency as evidenced by growth retardation, cataracts, and elevated blood lipids, is not uncommon in a population of children with diabetes in the Carolinas. To prevent more severe problems from occurring in later life, perhaps we must direct more careful attention to the adequacy of insulin replacement and to the consistency of diabetic control from the onset of diabetes.

Acknowledgment

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The various accidents of drowning, strangling, and apparent deaths, by blows, falls, hunger, cold, etc., likewise furnish opportunities of trying such (resuscitative efforts). Those, perhaps, who to appearance are killed by lightning, or by a violent agitation of the passions, as fear, joy, surprise, and such-like, might also be frequently recovered by the use of proper means, as blow-
Prevention and Cure of Diseases by Regimen and Simple Medicines, etc., Richard Folwell, 1799, pp. 425-426.

Primary Medical Care and Group Practice in North Carolina

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GROUP medical practice has become a significant pattern for the delivery of health care. The original Mayo Clinic model was perhaps the most influential organizational form of group practice during the first half of this century. However, in recent years the multispecialty regional referral group has been overshadowed, in terms of growth, by at least two newer forms. One of these is the multispecialty group organized to deliver primary care, which may be either fee-for-service (open to the general population), or prepaid (open only to those members of the population who have elected to enroll in an insurance plan which provides benefits in the form of services from the group.) The other newer form and the one which is showing the greatest growth currently is the single specialty group. Several national surveys have documented the growth and characteristics of these forms of practice.¹⁻³

In many communities throughout the country, group practice occupies the dominant position in the delivery of primary medical care. There has been considerable speculation that the presumed advantages of the group format make group practice a desirable means for achieving proposed national goals regarding medical care. Evidence for the strength of this idea may be found by examining the several national health care financing proposals currently before the United States Congress. The majority of them contains provisions which, in one way or another, recognize the group practice format as a preferred model for the delivery of health services.

There has also been much recent discussion of the problem of assuring the population access to health care at the primary level. The decline in numbers of general practitioners and the strong trend toward specialization have prompted the promotion of several possible solutions. Most of these have, in one way or another, centered on the production of more or a different type of medical manpower. There have been fewer examinations of the possible effect of alternative types of practice arrangements on access to primary care.^{4, 5}

A survey was undertaken in one state, North Carolina, to document the role of group medical practice in the delivery of primary medical care.

DEFINITIONS AND METHODS

Three terms which were central to the survey should be defined at the outset.

Primary medical care

For purposes of this survey, we have defined primary medical care as the range of ambulatory services provided or coordinated by a patient's personal physician, continuing over time, for the broad scope of medical and health maintenance needs. The practice of primary medical care is thus contrasted with other types of medical practice such as the episodic care typically provided in emergency rooms and industrial clinics, and specialty consultant services which make up the bulk of practice for many physicians and clinics. In past years the prototype provider of primary medical care was the "old family doctor." Today, the generalist, internist, pediatrician, and obstetrician-gynecologist are the most frequently identified "primary physicians." However, any physician may serve this role, given only that (s)he serves as the

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continuing entry point into a health care system for patients.

Group medical practice

In this survey we have used the definition of the American Medical Association for group medical practice:

The application of medical services by three or more physicians formally organized to provide medical consultation, diagnosis, and/or treatment through the joint use of equipment and personnel and with the income from medical practice distributed in accordance with methods previously determined by the group.⁸

Multispecialty groups are groups providing services in at least two specialties. Single specialty groups provide services in only one specialty. General practice groups are a special type of single specialty group composed exclusively of general practitioners.

Primary care group

We define a primary care group as a group medical practice having a *potential* for major involvement in primary medical care. For purposes of the survey we include within this definition single specialty internal medicine, pediatrics, and general practice groups; and multispecialty groups which include internists, pediatricians and/or generalists, but *not* single specialty obstetrics or surgical groups. We recognize that there is much anecdotal evidence suggesting the significant role that these last mentioned specialists may fill in delivering primary care; however, this function is a limited one for most obstetrician-gynecologists, and is clearly thought of as a secondary function by most surgeons.

In strict keeping with the AMA definition of group practice, the survey did not cover certain other non-private organizational patterns based on the group format, such as the clinics of teaching hospitals, faculty practice arrangements, federally funded comprehensive health care programs, student health services of colleges and universities, and other institutional (including military related) health care programs. Most of these programs, however, would no doubt otherwise meet our definition of a primary care group.

Methods

Using as a basic source the AMA's *Listing of Group Practice in the United States, 1967*,⁶ a list by county of location of all group practice organizations in North Carolina was sent to all district public health officers in the state for confirmation and additions. The University of North Carolina (Chapel Hill) collection of current telephone directories was then searched for additional listings of possible group practices. From these sources 165 medical practices were identified as possible group practice organizations. Subsequent follow-up revealed that 143 organizations conformed to the AMA definition of group practice.

A survey questionnaire was mailed during the fall and winter of 1970-1971 to 90 internal medicine, pediatric, general practice and multispecialty group practices. The questionnaire requested information on the origin, composition, and specialty staffing of the group; its non-physician employees, formal affiliations with other organizations, plans for staff expansion, patient referral source, practice volume, and proportionate primary care activity, night and emergency coverage, (primary) laboratory and radiology procedures, patient records, and performance evaluation activity.

Nineteen of the 90 groups receiving questionnaire were subsequently determined not to be true primary care group practices. The questionnaire was returned by 61 of the 71 true primary medical care group practices in North Carolina, or 85 percent. Questionnaires were obtained from 23 of 26 internal medicine, 16 of 18 pediatric, 12 of 14 general practice, and 11 of 13 multispecialty groups. The nonresponders were telephoned to obtain information on the physician staffing pattern, year of origin and legal structure of the group. Seventeen of the 71 primary medical care groups were composed of five or more physicians, and 12 of these were visited to obtain further information.

FINDINGS OF THE SURVEY

Number and type of group practice organizations

As of June, 1971, there were 143 independent group medical practices in North Carolina. An additional 12 associations of three or more physicians who practiced together were found, but could not be considered true group practices. The distribution of the groups by specialty staffing pattern is shown in Table 1.

Growth of primary care group practice

Of the 71 primary care groups, four (three multispecialty and one pediatric) originated before 1930. The number of primary care group practices has approximately doubled each decade since 1930.

Table 1

Group Practices in North Carolina, 1971 by Specialty Staffing and by Primary Care Potential

Specialty Type	Number
Major potential for primary care	
Multispecialty	13
Internal medicine	26
Pediatrics	18
General practice	14
	71
Other single specialty	
Obstetrics-gynecology	17
Surgical (general, thoracic, urology, orthopedics, ENT, ophthalmology, neuro)	36
Other (radiology, pathology, psychiatry, dermatology, neurology, subspecialties of internal medicine)	19
	72
TOTAL	143

own in Table 2. In the last decade internal medicine and general practice groups have been primarily responsible for the growth rate.

Table 2

Decade of Origin of Primary Care Groups, by Type of Group

Type of Group	Decade of Origin					Unknown	Total
	1921-1930	1931-1940	1941-1950	1951-1960	1961-1970		
Internal medicine	—	—	3	7	13	3	26
Pediatrics	1	1	2	7	5	2	18
General practice	—	—	2	2	9	1	14
Multispecialty	3	2	1	2	1	4	13
Other specialists	4	3	8	18	28		
CUMULATIVE	4	7	15	33	61	10	71

Group size

Almost half of the primary care group practices include three physicians, the minimum size necessary for conformance with the AMA definition of a group medical practice. The single specialty groups as compared with multispecialty groups are, as expected, distributed much more toward smaller group size. The distribution by specialty and size of all North Carolina groups is shown in Table 3.

Table 3

Group Practices in North Carolina, 1971, by Specialty and Size

Specialty	Group Size			Total Groups
	3	4	5 or More	
Group potential for primary care				
Multispecialty	0	1	12	13
Internal medicine	15	8	3	26
Pediatrics	10	7	1	18
General practice	9	4	1	14
Sub-total	34	20	17	71
Single specialty				
Obstetrics-gynecology	13	3	1	17
Surgical	21	9	6	36
Other	8	7	4	19
Sub-total	42	19	11	72
TOTAL	76	39	28	143

Number of physicians in primary care group practice

There were 359 physicians practicing in groups with major potential for primary care as of June, 1971. The "primary physician specialists" — internal medicine, pediatricians, and generalists — accounted for 80 or 80 percent of the total. The other specialists were, of course, uniformly located in multispecialty groups, where they comprised 46 percent of multispecialty group physician manpower. The distribution by specialty and type of group is shown in Table 4.

Physicians in primary care groups and total N. C. physician resources

In the last year for which reliable figures are available, 1968, there were some 2,938 physicians in

Table 4

Primary and Other Physicians in Primary Care Group Practice by Specialty

Physician Specialty	Single Specialty and General Practice Groups	Multispecialty Groups	Total
Internal medicine	96	43	139
Pediatrics	65	11	76
General practice	48	26	74
Other specialists	—	70	70
TOTAL	209	150	359

active private practice in North Carolina, available for patient care.⁷ About 20 percent of these physicians are in group practice and 12 percent are in primary care groups. Table 5 shows the distribution of physicians by specialty in primary care groups as compared to all North Carolina physicians.

Table 5

Number and Percent of All North Carolina Physicians in Primary Care Group Practice, by Specialty

Specialty	Total Number in Private Practice, 1968	Number in Primary Care Groups, 1971	Percent in Primary Care Group Practice
Internal medicine	458	139	30
Pediatrics	208	76	37
General practice	1054	74	7
Other specialists	1218	70*	6
TOTAL	2938	359	12

* An additional 252 non-primary physician specialists were in single specialty group practice; hence the number of all group practice physicians was 611, or 20 percent of total physicians in private practice.

About one third of all active private practice internists and pediatricians and one fifteenth of general practitioners are in organized groups. General practice, it appears, remains the domain of the solo practitioner and two-physician partnership.

Proportionate volume of primary medical care

Almost three fourths of the internal medicine, pediatric and general practice groups estimate 80 percent or more of their office practice to be primary medical care. In contrast, more than half of the multispecialty groups expect less than 80 percent of their practice to be primary care activity. Presumably this difference is because some of the multispecialty groups prefer to emphasize a consultant role in their communities. Table 6 presents the distribution of estimated primary care activity in primary care groups.

Planned expansion of physician staff

The impact of group practice as a source of medical care for the population can increase in two ways:

Table 6
Estimated Percent of Primary Care Service Activity, by Specialty

Specialty Type and Number of Groups	Estimated Percent of Primary Care Activity				
	0-19%	20-39%	40-59%	60-79%	80-100%
Multispecialty (9)	1	1	2	1	4
Internal medicine (23)	—	2	2	2	17
Pediatrics (15)	—	—	1	2	12
General practice (9)	—	—	—	2	7
TOTAL (56)*	1	3	5	7	40

* Five of the 61 groups returning questionnaires did not respond to this question.

by the formation of new groups and by the expansion of existing ones. Most of the large nationally known group practice organizations began with relatively small physician staffs and grew actively by recruiting more physicians as additional demand for medical service was felt by the group. Table 7 presents information on planned recruitment of additional physicians by existing primary care group practices within two years from the time of the survey. The majority of primary care groups plan recruitment of one or more additional physicians. There is a trend toward more planned expansion with increasing group size.

Table 7
Planned Physician Staff Expansion by Specialty and Size of Groups

Specialty Type	No. Groups	No. of Groups Planning Physician Staff Expansion	No. New Physicians Sought	Percent Planning Additional Physicians
Multispecialty	10	6	14	60%
Internal medicine	23	13	17	56%
Pediatrics	16	6	6	37%
General practice	12	6	6	50%
Current Group Size				
3	29	13	14	45%
4	16	8	11	50%
5 or more	16	10	18	63%
TOTAL	61	31	43	50%

Use of allied health personnel

Primary care groups employ a broad range of allied health personnel for professional, business, laboratory, and custodial purposes. A ratio of 2.63 allied health personnel per physician was found in this survey. This ratio is very similar to the 2.51 allied health personnel per physician reported in the 1969 AMA survey of all group practices in the United States.

Several types of allied health workers require special note. These personnel are variously known as physician surrogates or physician extenders, and they have a potentially large role in the delivery of primary medical care. Physician surrogates include the family or pediatric nurse practitioner, the physi-

cian assistant or associate, the pediatric associate, and the nurse midwife. Nine primary care groups indicated that they used physician surrogates at the time of the survey. Three of these were pediatric groups employing pediatric nurse practitioners. Family nurse practitioners are used by one general practice group and two multispecialty groups. Two internal medicine groups and one general practice group stated that they employed physician assistants. Another five groups indicated that they were considering the recruitment of one of these several types of surrogates.

Extramural service affiliations

About one third of primary care groups have formal arrangements with other organizations for the provision of medical care. The majority of these affiliations are with local public health departments for medical staffing of pediatric, prenatal, family planning, and other public health clinics. In addition, several groups have contracts to provide medical care in colleges, boarding schools, summer camps and prisons.

Availability of primary care groups to new patients

There are wide variations in the degree to which primary care group practices are available to new patients. Adult non-emergency patients without appointments (walk-ins) would have considerably more difficulty being seen in an internal medicine group than in a general practice group. Thirty-five percent of the 23 internal medicine groups and nine of the general practice groups stated that they could see new patients without appointments during regular office hours. Forty-seven percent of the pediatric groups were able to see new patients without appointments during their regular hours; however, only one of them were accessible to new patients in the evening. It is noted, however, that many internal medicine groups wrote on the questionnaire that they participate in a rotation schedule for emergency room coverage at one or more local hospitals.

Standardized clinical procedures

One of the potentials of group practice is achievement of efficiency, and perhaps quality, through standardized procedures. Primary medical care groups were asked if they followed a standard set of laboratory and x-ray diagnostic procedures for all new patients and patients who present for a routine physical examination. The results are summarized in Table 8.

The discriminating factor in having or not having an agreed upon set of laboratory and x-ray procedures is not immediately apparent; however, the majority of internal medicine and pediatric groups have some standardized procedures. While no multispecialty group reported such procedures, it is quite possible that the internists, pediatricians and/or generalists as a subset of the entire group might have

Table 8

Groups with Standardized Laboratory and X-ray Procedures for New Patients

Type of Group		Do Have	Do Not Have
Multispecialty	10	0	10
Internal medicine	24	18	6
Pediatrics	15	10	5
General practice	11	4	7
TOTAL	58*	32	26

Three of the 61 groups returning did not respond to this question.

Standard procedures in effect for the evaluation of new patients.

Record filing system

One manifestation of a primary care group's orientation toward an individual versus family centered practice is its method of filing charts. Table 9 summarizes the information on the system of filing patient charts used by the primary care groups.

Pediatric groups appear to be much more likely to file their patient records by family, while maintenance of individuality of practice within an organized group is an apparent objective of three general practice groups as indicated by the record filing system they

Table 9

Record Filing System Used by Primary Care Groups

Type of Group and Number	By Individual	By Family	By Physician
Multispecialty (8)	8	—	—
Internal medicine (23)	21	2	—
Pediatrics (15)	6	9	—
General practice (12)	7	2	3
TOTAL 58*	42	13	3

Three of the 61 groups returning questionnaires did not respond to this question.

Performance assessment in office practice

There has been considerable discussion and interest regarding quality review. This focus is currently centered in the federal financing programs, Medicare and Medicaid. Various peer review methods have long been a standard part of hospital practice in, for example, death conferences, tissue committees, and, more recently, with utilization review committees. To ascertain the current practice of primary care groups in regard to performance review, they were asked about the practice of regular formal review of the quality of patient care in their ambulatory practice. The results are summarized in Table 10.

Although the questionnaire specifically requested information on the existence of a formal review procedure, a few groups responded that they had "informal" procedures; these responses are not tabulated in the "has formal review" column in Table 10. Informal procedures ranged from "daily review,

Table 10

Regular Method for Evaluation of Performance in Ambulatory Practice

Type of Group and Number	Has Formal Review	Has No Formal Review
Multispecialty (10)	1	9
Internal medicine (23)	3	20
Pediatrics (16)	—	16
General practice (12)	—	12
TOTAL 61	4	57

especially for inpatients," to a written evaluation by one group member of randomly drawn charts of other group physicians.

SUMMARY

A survey was undertaken in North Carolina to document the role of group medical practice in the delivery of primary medical care. Approximately 20 percent of all privately practicing physicians in North Carolina are organized in 143 independent group practices. Twelve percent of private physicians are in 71 primary care groups, defined as group medical practice having a potential for major involvement in primary medical care. These accounted for about one third of active privately practicing internists and pediatricians in the state and about one fifteenth of general practitioners.

Primary care group practice in North Carolina had its origin during the 1920s. The number of primary care groups has increased approximately 100 percent during each decade since then. Three quarters of the groups with a potential for primary medical care estimate 80 percent or more of their practice volume to be primary medical care activity.

As an organizational form for the delivery of medical care, group medical practice is increasing in North Carolina as it is also in the nation. Groups having a physician staffing pattern that suggests a potential for major involvement in primary care at present constitute a majority of all medical groups in North Carolina. It is considered likely that group practice will play an even more significant role in the delivery of primary care in the future.

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Initial Care for Lacerations of Flexor Tendons of the Hand

Robert B. Winslow, M.D., and A. Griswold Bevin, M.D.

SURGERY of the hand has become increasingly sophisticated since Bunnell¹ formalized it in his well-known textbook, first published in 1944. Since that time, great contributions have been made by surgeons from many different specialties—especially plastic, orthopedic, and general surgery. Bunnell taught that the area of the digital theca or flexor tendon sheath was “no man’s land.” He recommended that no primary reconstruction be attempted (instead only cleansing the wound and closing the skin) when the flexor tendons within this area were lacerated; a second stage tendon graft, in which both anastomoses were placed outside “no man’s land,” was to be carried out after the wound healed. However, owing to refinement in techniques, improved understanding of tendon physiology and wound healing, and the development of hand rehabilitation centers, this sound dictum has become modified.

Today, all major hand surgery requiring primary reconstruction is performed under tourniquet ischemia, in a formal operating room with excellent lighting and instruments, under anesthesia, and with the aid of experienced assistants. Two-, four-, and ten-power magnification is often utilized for suturing and for the most accurate realignment of tissues. Atraumatic technique is a *sine qua non*, as is the use of either removable or very fine, nonreactive, strong sutures. Excellent postoperative care must be available—frequent follow-up and accessibility to closely supervised, occupational and physical therapy programs. Such care must be available on a daily basis, if needed. Long-term follow-up is equally essential

since it may help the patient toward acceptable function and because it will provide the surgeon with additional information about his work.

The work of Boyes,^{2, 3} Peacock,^{4, 5} Verdan,⁶ and others, as well as our own, carried out under the conditions mentioned, leads us to advocate the primary repair of flexor tendon lacerations (even in Bunnell’s “no man’s land”) in selected cases. Thus the term “some man’s land” evolved.⁷

Although every eminent hand surgeon seems to have his own slightly varied criteria for selecting patients as candidates for primary repair, none recommends primary tenorrhaphy for all flexor tendon lacerations. The selection of patients who qualify for primary repair depends on several factors: the patient’s age, the nature of the injury, the location of the wound, the structures involved, the occupation of the patient, the initial care already given, and the capability of the surgeon and the facilities at his disposal. It is not important that the surgeon be a plastic, orthopedic, or general surgeon; but it is essential that he be well-trained in surgery of the hand. If he lacks familiarity with the anatomy and surgery of the hand, the surgeon, regardless of his talent, should not undertake this kind of surgery. Furthermore, even under the most ideal conditions, not all patients can or should, be treated by definitive primary repair.

The most successful results in primary repair have been possible because of the surgeon’s intimate knowledge of the anatomy of the hand and his experience in the field. Primary repair, be it anastomosis or graft, can be successful. It can insure better and more reliable results—with less scarring, expense, and disability—than other approaches used in ideal wounds. An ideal wound is clean, less than six to eight hours old, and has only one or two tendon

From the Division of Plastic and Reconstructive Surgery and Surgery of the Hand, and The Hand Rehabilitation Center, Department of Surgery, University of North Carolina School of Medicine and the North Carolina Memorial Hospital, Chapel Hill, North Carolina.

erated within it. It occurs in a young patient who is supple, clean hands, and no apparent mitigating cause or deformity. The priorities of wound care dictate that before any consideration can be given to flexor tendon reconstruction, the wound must be cleaned, accompanying fractures reduced and stabilized, nerves repaired, and adequate skin cover obtained. In certain circumstances, however, dirty wounds can be made clean by debridement or by actual wound excision. Inadequate or damaged local tissue can best be replaced by grafts or cross-finger flaps. Although six to eight hours may be sufficient, with antibiotic coverage and splinting, primary repair can be delayed for twelve to twenty-four hours.⁸ Jamson⁹ even recommends waiting five days to perform deferred primary repair on a scheduled, elective basis. He claims that the results are comparable to more aggressive, earlier approaches. In these undertakings, poor results are infrequent and disasters are rare.

If primary or deferred primary flexor tendon reconstruction cannot be safely accomplished, such well known alternatives as secondary tenorrhaphy and free tendon grafting can be performed. Less well known, but advantageous, is the (now accepted) secondary scar resection with construction of pulleys, and the insertion of a Silastic® rod.¹⁰⁻¹⁴ After approximately three months, tendon continuity may be reestablished through the scar-free tunnel formed around the rod. This can be done by either the traditional free graft or the two-stage tenoplasty technique.¹⁵⁻¹⁸ Neither is performed until protective sensation has been restored, adequate joint supple-ness has been gained, and sufficient skin cover has been provided. According to Boyes,¹⁹ only the surgeon who can perform this surgery is qualified to perform the initial surgery.

New techniques, materials, and approaches are continually being sought and evaluated. New developments that seem worthwhile are disseminated. Although primary repair in flexor tendon injuries is recommended when feasible (rather than simple closure of the skin wound), not every hand surgeon should perform primary repair. The occasional hand surgeon—who is not well acquainted with current concepts, who is caught at night between busy office/hospital days, who has inadequate help and less than ideal operating facilities, who is without magnification, and who is without the desire or facilities for compulsive, prolonged postoperative care—should not repair all flexor tendons primarily. Under these circumstances, the best treatment is to clean the wound and close the skin.

Whether to perform some kind of primary repair, or whether to close the skin and perform secondary reconstruction later, is a crucial decision. Primary repair, if successful, results in the shortest duration of disability, the least expense, and the least scarring. Often, however, failure to adhere to the basic

principles mentioned results in an unsatisfactory outcome; it then becomes necessary to implement complex secondary reconstructive procedures which are time-consuming and expensive, and which probably will be less satisfactory than an initially well planned and performed deferred or secondary procedure. Thus, even under the best of circumstances, the experienced hand surgeon must exercise caution in deciding whether to perform primary repair. Although Chase²⁰ has acknowledged the theoretical, actual, and documented advantages of primary repair, he still recommends skin closure and secondary reconstruction.

Considerable exposure to the results of primary flexor tendon surgery is afforded by the Hand Rehabilitation Center of the University of North Carolina School of Medicine at Chapel Hill. Those patients whose simple and uncomplicated postoperative course has resulted in a prompt return of acceptable function are not referred to us. We see patients with delayed healing, wound infections, disrupted anastomoses, poor function caused by stiff joints, or adherent anastomoses. Thus, in our experience, we have had an opportunity to care for many patients who have had unsatisfactory results, as well as many patients who have had primary complex injuries. We have seen examples of nerves anastomosed to tendons; nerves anastomosed by a Bunnell woven suture of silk; finger tenorrhaphies done by using mattress sutures of 2-0 silk; primary tenorrhaphies in which adjacent lacerated nerve(s) were left unrepaired; primary neurorrhaphies and tenorrhaphies performed in uncleaned wounds; dressings covered by a cast and left unchanged for as long as four or six weeks; active motion begun at one week, without protection; tenorrhaphies in the distal finger, done with cotton sutures; and anastomoses wrapped in Silastic® sheet. These experiences are not unique; Boyes¹⁹ reported five instances of "board certified" surgeons using segments of the median nerve for a free tendon graft. In each case cited there has been a disastrous result, requiring prolonged therapy and further surgery which might well have been avoided by adhering to the principles stressed herein.

The surgeon—especially the hand surgeon—is not compelled to perform primary tendon repair within eight hours of injury. Owing to advanced transportation in this state, a patient can be taken, within a few hours (by helicopter, if necessary), to an adequate center with special facilities for hand surgery. Within four to eight hours, a patient can be taken to such a center by routine modes of travel. Hopefully, those centers which are not adequately equipped to give comprehensive care to flexor tendon injuries will recognize the advantages (to themselves, as well as to their patients) of sending the victim to the nearest hand surgeon, regardless of time and distance. Primary repair—the best treatment in carefully selected patients—can then be performed in a

manner and under conditions that justify its use. Under less than ideal conditions, primary tendon repair is unjustified.

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No part of the practice of medicine is of greater importance, or merits more the attention of the physician, as many lives are lost, and numbers ruin their health, by cold bathing, and an imprudent use of mineral waters.—*William Buchan: Domestic Medicine, or a Treatise on the Prevention and Cure of Diseases by Regimen and Simple Medicines, etc., Richard Folwell, 1799, p. 426.*

Editorials

SUGGESTIONS FOR AUTHORS

The NORTH CAROLINA MEDICAL JOURNAL welcomes original contributions to its scientific pages, expecting only that they be under review solely by this JOURNAL at a given time, and that they follow a few simple guidelines. The guidelines are as follows:

1. Subject Matter

Educational articles, especially those in which particular applications to the practice of medicine in North Carolina are developed, are one of the main objectives of this JOURNAL.

Articles reporting original work by North Carolina physicians are invited, whether the work is done in a clinic, a laboratory, or both. The editor and his consultants will evaluate the work by the usual criteria, including a proper discussion of previous work, control observations, and statistical tests where indicated.

Historical articles, especially those dealing with local history, are considered of real value and interest.

2. Manuscripts

An original and a carbon copy of the manuscript should be submitted, one for review by the editorial staff, the other for referees. The manuscript should be typed on standard-size paper, double-spaced, with wide margins (one inch on each side).

3. Bibliographic References

References to books and articles should be indicated by consecutive numerals throughout the text and then typed, double-spaced, on a separate page at the end of the manuscript.

script. Books and articles not indicated by numerals in the paper should not be included.

References will be much more valuable to the reader if they are given in a proper form and contain the full information necessary to locate them easily. The NORTH CAROLINA MEDICAL JOURNAL follows the form used in the journals of the American Medical Association and the *Index Medicus*, giving the author's surname and initials, title of the article, name of the periodical, volume, inclusive page numbers, and the date of publication. It is believed that this style makes it easier for the reader to judge whether the reference is likely to prove useful to him, and enables him to locate it more quickly.

4. Tables and Illustrations

Tables and legends for illustrations should be typed on separate sheets of paper. The illustrations should be glossy black-and-white prints or line drawings. It is necessary to obtain permission from the author or publisher to reproduce illustrations which have been published elsewhere. Costs in excess of \$15.00 for illustrations are borne by the author. Costs for setting of tables are also borne by the author as are charges for art work which might be needed for proper printing of figures.

5. Style


The style followed by this JOURNAL will be, in general, that outlined in the Style Book issued by the Scientific Publications Division of the American Medical Association, John H. Talbot, M.D., director. All manuscripts are subject to editorial revision for such matters as spelling, grammar, and the like.

By following the above suggestions, writers will greatly expedite the publication of papers accepted by the NORTH CAROLINA MEDICAL JOURNAL.

Without a proper discrimination with regard to the disease and constitution of the patient, the most powerful medicine is more likely to do harm than good. The same physician, who, by cold bathing, cured Augustus, by an imprudent use of the same medicine, killed his heir. This induced the Roman senate to make laws for regulating the baths, and preventing the numerous evils which arose from an imprudent and promiscuous use of those elegant and fashionable pieces of luxury.—*William Buchan: Domestic Medicine, or a Treatise on the Prevention and Cure of Diseases by Regimen and Simple Medicines, etc., Richard Folwell, 1799, p. 426.*



The irritations of man's day are often reflected in his gut.



The causes of irritable colon and the diarrhea symptoms that often accompany it can be as diverse as the systemic and emotional irritations man is faced with daily.

Although the mucoid nature of stools and the occurrence of diarrheal episodes coincident with times of emotional stress may be valuable clues to the functional nature of the disorder, irritable colon must often be diagnosed by exclusion. Such diagnostic exploration takes time. Discovery of the nature of any emotional problems may take more. During that time, Lomotil® is an ideal agent for controlling diarrheal symptoms.

Lomotil tablets are small, easy to carry and easy to take. They act promptly and effectively. Secondary effects are relatively infrequent and once the first force of the diarrhea is controlled maintenance is frequently effective on as little as one fourth of the initial dosage.

These same characteristics make Lomotil useful in controlling the diarrhea associated with gastroenteritis, antibiotic therapy and acute infections.



IMPORTANT INFORMATION: This is a Schedule V substance by Federal law; diphenoxylate HCl is chemically related to meperidine. In case of overdosage or individual hypersensitivity, reactions similar to those after meperidine or morphine overdosage may occur; treatment is similar to that for meperidine or morphine intoxication (prolonged and careful monitoring). Respiratory depression may recur in spite of an initial response to Nalline® (nalorphine HCl) or may be evidenced as late as 30 hours after ingestion. LOMOTIL IS NOT AN INNOCUOUS DRUG AND DOSAGE RECOMMENDATIONS SHOULD BE STRICTLY ADHERED TO, ESPECIALLY IN CHILDREN. THIS MEDICATION SHOULD BE KEPT OUT OF REACH OF CHILDREN.

Indications: Lomotil is effective as adjunctive therapy in the management of diarrhea.

Contraindications: In children less than 2 years, due to the decreased safety margin in younger age groups, and in patients who are jaundiced or hypersensitive to diphenoxylate HCl or atropine.

Warnings: Use with caution in young children, because of variable response, and with extreme caution in patients with cirrhosis and other advanced hepatic disease or abnormal liver function tests, because of possible hepatic coma. Diphenoxylate HCl may potentiate the action of barbiturates, tranquilizers and alcohol. In theory, the concurrent use with monoamine oxidase inhibitors could precipitate hypertensive crisis.

Usage in pregnancy: Weigh the potential benefits against possible risks before using during pregnancy, lactation or in women of childbearing age. Diphenoxylate HCl and atropine are secreted in the breast milk of nursing mothers.

Precautions: Addiction (dependency) to diphenoxylate HCl is theoretically possible at high dosage. Do not exceed recommended dosages. Administer with caution to patients receiving addicting drugs or known to be addiction prone or having a history of drug abuse. The subtherapeutic amount of atropine is added to discourage deliberate overdosage; strictly observe contraindications, warnings and precautions for atropine; use with caution in children since signs of atropinism may occur even with the recommended dosage.

Adverse reactions: Atropine effects include dryness of skin and mucous membranes, flushing and urinary retention. Other side effects with Lomotil include nausea, sedation, vomiting, swelling of the gums, abdominal discomfort, respiratory depression, numbness of the extremities, headache, dizziness, depression, malaise, drowsiness, coma, lethargy, anorexia, restlessness, euphoria, pruritus, angioneurotic edema, giant urticaria and paralytic ileus.

Dosage and administration: Lomotil is contraindicated in children less than 2 years old. Use only Lomotil liquid for children 2 to 12 years old. For ages 2 to 5 years, 4 ml. (2 mg.) t.i.d.; 5 to 8 years, 4 ml. (2 mg.) q.i.d.; 8 to 12 years, 4 ml. (2 mg.) 5 times daily; adults, two tablets (5 mg.) t.i.d. to two tablets (5 mg.) q.i.d. or two regular teaspoonfuls (10 ml., 5 mg.) q.i.d. Maintenance dosage may be as low as one fourth of the initial dosage. Make downward dosage adjustment as soon as initial symptoms are controlled.

Overdosage: Keep the medication out of the reach of children since accidental overdosage may cause severe, even fatal, respiratory depression. Signs of overdosage include flushing, lethargy or coma, hypotonic reflexes, nystagmus, pinpoint pupils, tachycardia and respiratory depression which may occur 12 to 30 hours after overdose. Evacuate stomach by lavage, establish a patent airway and, when necessary, assist respiration mechanically. Use a narcotic antagonist in severe respiratory depression. Observation should extend over at least 48 hours.

Dosage forms: Tablets, 2.5 mg. of diphenoxylate HCl with 0.025 mg. of atropine sulfate. Liquid, 2.5 mg. of diphenoxylate HCl and 0.025 mg. of atropine sulfate per 5 ml. A plastic dropper calibrated in increments of 1/2 ml. (total capacity, 2 ml.) accompanies each 2-oz. bottle of Lomotil liquid.

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Emergency Medical Services



HISTORICAL BACKGROUND OF THE AMA COMMITTEE ON COMMUNITY EMERGENCY SERVICES

**William E. Burnette, Secretary
AMA Committee on Community Emergency
Services**

In May of 1970, the Board of Trustees established the AMA Committee on Community Emergency Services to 1) maintain effective liaison with state medical societies in the area of EMS, 2) develop disaster programs, and 3) maintain liaison with the government.

Since its inception, it has been very active in emergency medical services and has had a major role in attempts to implement Federal legislation on emergency medical services. In November 1971, the committee submitted a report with their ideas for improving emergency medical services: 1) All medical societies should assign a high priority to EMS, 2)

Special emphasis on EMS in rural areas. 3) Well equipped and staffed emergency vehicles. 4) Development of emergency medical service councils. 5) The medical profession should take a leadership role in quality control. 6) A single Federal agency should be responsible.

A model disaster program is being developed at O'Hare Airport in Chicago. They have worked with HEW on medical self-help programs. They have been making recommendations on a standard format for emergency medical services telephones.

The committee is committed to serving the constituent societies in their quest to improve emergency medical services throughout the nation.

Abstracted by George Johnson, Jr., M.D.

From "Emergency Medicine Today." The original article may be obtained from the American Medical Association, 535 North Dearborn Street, Chicago, Illinois 60610.

Committees and Organizations

COMMITTEE ON HEALTH CARE DELIVERY Southern Pines, Sept. 28, 1973

The committee adopted the following resolution, on motion by Dr. Patrick D. Kenan:

We propose that the primary mission of the Committee on Health Care Delivery be to concern itself with the problems of health care accessibility.

—PATRICK D. KENAN, M.D., *Chairman*

COMMITTEE ON HOSPITAL AND PROFESSIONAL RELATIONS Southern Pines, Sept. 27, 1973

The committee adopted the following resolutions:

1) This committee approves in principle the request of the North Carolina Society of Internal Medicine to study methods of improving medical records and that the North Carolina Medical Society and

North Carolina Hospital Association should in consultation form a committee to study and demonstrate solutions to this problem, and employ professional consultants if necessary.

2) This committee recommends to the Medical Society that it jointly with the North Carolina Hospital Association prepare guidelines for community hospitals regarding professional fees for professional services by interns and residents in training.

3) This committee recommends to the Medical Society to take steps to obtain legal ruling regarding the rights and hazards of physicians and hospital employees drawing blood for alcohol determination at the request of law enforcement officers and after obtaining same, publicize well to the medical profession and hospitals as soon as possible.

—JOE M. VAN HOY, M.D., *Chairman*

Bulletin Board

WHAT? WHEN? WHERE?

In Continuing Education

January 1974

Place" and "sponsor" are listed only where these differ from the place and group or institution listed under "for information.")

In North Carolina

January 18-19

Management of Peptic Ulcer (Medical and Surgical Approaches), 4th Annual Surgical Symposium
Place: Babcock Auditorium

Fee: \$100.00

For Information: Emery C. Miller, M.D., Associate Dean for Continuing Education, Bowman Gray School of Medicine, Winston-Salem 27103

February 1-2

4 Leadership Conference, North Carolina Medical Society

This conference is designed especially for new officers, committee members, and others who carry leadership responsibility for any activities of the Society; it is open to a member of the Society.

Place: North Carolina Medical Society Building, Raleigh
Please note change from previous location.)

For Information: Mr. William N. Hilliard, Executive Director, P. O. Box 27167, Raleigh 27611

February 13

Viggo M. Johnson Memorial Lecture

Place: Babcock Auditorium (8:00 p.m.)

For Information: Emery C. Miller, M.D., Associate Dean for Continuing Education, Bowman Gray School of Medicine, Winston-Salem 27103

February 15-16

3 Annual Watts Medical and Surgical Symposium

Place: Durham Hotel & Motel, Durham

Sponsor: Watts Hospital Medical Staff

For Information: Clarence Bailey, M.D., 1824 Hillandale Road, Durham 27705

February 20

Second District Medical Society Annual Meeting

Place: Ramada Inn, New Bern

Scientific Session—2:00 p.m.; banquet—7:00 p.m., speaker, George Gilbert, M.D., President, North Carolina Medical Society

For Information: Zack J. Waters, M.D., 800 Hospital Drive, New Bern 28560

March 14

Malignant Disease Symposium on Carcinoma of the Lung
Sponsors: Department of Surgery and the Office of Continuing Education

For Information: Miss Ann Francis, Administrative Assistant, Office of Continuing Education, School of Medicine, UNC, Chapel Hill 27514

March 15-16

14th Annual E. C. Hamblen Symposium in Reproductive Biology and Family Planning. Basic themes: The Manage-

ment of High-Risk Obstetrics and Newer Advances in the Treatment of Infertility

Sponsor: Department of Obstetrics and Gynecology

Tuition: \$25.00; no charge for residents or students

For Information: Charles B. Hammond, M.D., P. O. Box 3143, Duke University Medical Center, Durham, N. C. 27710

March 21-23

Hematology and Oncology Post Graduate Course

Place: Duke University School of Medicine

Director: Wayne Rundles, M.D., Professor of Hematology, Duke University.

For Information and registration forms: American College of Physicians, 4200 Pine Street, Philadelphia, Pennsylvania 19104

March 25-27

Tutorial Postgraduate Course: Radiology of the Chest

This course is designed both for radiologists in training and those in practice. The tutorial format and limited registration will allow a larger than usual faculty-student ratio and personalized instruction to those enrolled. Guest faculty have been chosen both for their excellence in their respective topics, and for their effective use of the tutorial approach. During one hour tutorial sessions 12 registrants will join one faculty member in a separate quiet room with a bank of viewboxes for organized film reading-discussions, with 10-12 case presentations on a basic subject or two. Registrants are invited to bring interesting cases for consultation with the "experts."

Place: Durham Hotel-Motel, Durham

Credit: 21 hours AMA "Category One" accreditation

Fee: \$200.00

For Information: Robert McLelland, M.D., Department of Radiology, Box 3808, Duke University Medical Center, Durham 27710

March 26-28

Cardiac Arrhythmia Course

Place: Duke Hospital Orthopedic Clinic, Room 1367

For Information: Galen Wagner, M.D., Box 3327, Duke University Medical Center, Durham 27710

March 28

Wilson Memorial Hospital Symposium on Obesity, Nutrition & Physical Fitness

Sponsors: Wilson County Medical Society and the North Carolina Academy of Family Physicians

For Information: Gloria Graham, M.D., Wilson Memorial Hospital, Wilson 27893

April 1-2

Postgraduate Course: Obstetrics and Gynecology

Place: Babcock Auditorium

For Information: Emery C. Miller, M.D., Associate Dean for Continuing Education, Bowman Gray School of Medicine, Winston-Salem 27103

April 27

Craven-Pamlico Annual Medical Society Symposium

Place: Ramada Inn, New Bern

For Information: Zack J. Waters, M.D., 800 Hospital Drive, New Bern 28560

May 4-5

Principles of Practical Oxygen Therapy

Sponsors: Department of Anesthesiology in cooperation with the Office of Continuing Education

For Information: Miss Ann Francis, Administrative Assistant, Office of Continuing Education, School of Medicine, UNC, Chapel Hill 27514

May 14-16

The Neuro-endocrinology Symposium: Neurobiology of CNS—Hormone Interaction
Place: UNC Student Union Building, Great Hall
Sponsors: UNC Neurobiology Program and Laboratories for Reproductive Biology
For Information: Miss Ann Francis, Administrative Assistant, Office of Continuing Education, UNC School of Medicine, Chapel Hill 27514

May 15

Ethel Nash Day Program
Place: Cline Auditorium, Time: 1:00-5:30 p.m.
Sponsor: Department of Obstetrics and Gynecology
For Information: Miss Ann Francis, Administrative Assistant, Office of Continuing Education, UNC School of Medicine, Chapel Hill 27514

May 29-30

Hypertension: Critical Problems—25th Annual Meeting and Scientific Sessions, North Carolina Heart Association
Place: Hyatt House and Convention Center, Winston-Salem
Designed especially for nurses and physicians
For Information: North Carolina Heart Association, 1 Heart Circle, Chapel Hill 27514

In Contiguous States

January 18-19

The Tennessee Regional Meeting of the American College of Physicians
Place: Holiday Inn Vanderbilt, Nashville
Sponsor: American College of Physicians
For Information: Gerald I. Plitman, M.D., 1734 Madison Avenue, Memphis, Tennessee 38104

January 21-22

Extending the Scope of Nursing Practice
For Information: Medical University of South Carolina, Division of Continuing Education, 800 Barre Street, Charleston, S. C. 29401

January 21-24

The Alton D. Brashear Postgraduate Course in Head and Neck Anatomy
The primary teaching method of this course is the dissection of the head and neck. Fresh specimens (unpreserved) are used to be as life-like as possible. Individual surgical approaches and manipulations are welcomed. Lectures and demonstrations will augment the laboratory dissections.

On Friday, January 25 the laboratory will be open and specimens will be available if special individual dissection is desired. All members of the staff of the department of anatomy will be available for consultation and assistance. Registration: Tuition \$175.00; \$90.00 for students in residency programs. Class size limited to 32; applications processed in order received. Course open to any individual who holds one of the following degrees: M.D., D.D.S., D.M.D., Ph.D. or equivalent.

Sponsors: Department of Anatomy in cooperation with the Department of Continuing Education, Schools of Medicine and Dentistry.

For Information: Dr. Hugo R. Seibel, Department of Anatomy, Medical College of Virginia, Box 906—MCV Station, Richmond, Virginia 23298

February 3-9

Fifth Annual Family Practice Refresher Course
Place: Mills Hyatt House Hotel
Registration open through January 21; enrollment limited to 100.
Tuition: \$140.00, payable in advance on or before January 21.

For Information: Dr. Vince Moseley, Director, Division of Continuing Education, Medical University of South Carolina, 80 Barre Street, Charleston, S. C. 29401

February 7-8

27th Annual Stoneburner Lecture Series: Clinical Advances in Medical and Surgical Neurology
Place: Baruch Auditorium (Egyptian Building)

Sponsors: Department of Continuing Education and the Division of Neurosurgery
Credit: 13½ hours AAFP applied for; AMA accreditation
Fee: \$95.00

For Information: David B. Walthall, III, M.D., Director, Department of Continuing Education, Medical College of Virginia, Box 91, MCV Station, Richmond, Virginia 23298

February 21-23

Annual Meeting of the Virginia Chapter of the American Academy of Pediatrics
Place: Colonial Williamsburg
Program: Friday night banquet guest speaker—Dr. James B. Gillespie, President, American Academy of Pediatrics
Friday and Saturday scientific sessions include: New Trends in Management of Respiratory Distress; Supportive Therapy for the Child with Inborn Error of Metabolism; Non-Bacterial Respiratory Tract Infections; Sudden Infant Death Syndrome; Viral Vaccines; Adaptation in School of the Child with Borderline Cerebral Handicaps.

For Information: James H. Stallings, Jr., M.D., 6503 North 29th Street, Arlington, Virginia 22213.

March 7-9

Sports Medicine Problems in All Age Groups
Place: Page Auditorium, Duke University, Durham, N. C.
Sponsor: American Academy of Orthopaedic Surgeons
Fee: \$150.00; residents \$50.00
For Information: The American Academy of Orthopaedic Surgeons, 430 North Michigan Avenue, Chicago, Illinois 60611

March 10-14

Postgraduate Course in Gastrointestinal Radiology
Place: Williamsburg Conference Center, Williamsburg, Virginia
Sponsors: Department of Radiology and the Department of Continuing Medical Education
Fee: \$175.00; \$75.00 for residents
For Information: Department of Continuing Education, Medical College of Virginia, Box 91, MCV Station, Richmond, Virginia 23298

April 16

Fourth Annual Charles W. Thomas Lecture
Place: George Ben Johnston Auditorium
Sponsor: Division of Connective Tissue Diseases
For Information: Department of Continuing Education, Medical College of Virginia, Box 91, MCV Station, Richmond, Virginia 23298

April 20-24

"Selection of Materials for Reconstructive Surgery," the Sixth International Biomaterials Symposium
Designed to bring together clinicians in orthopedics, oral surgery, plastic and reconstructive surgery with leading researchers in biomaterials, biomechanics, biophysics and experimental surgery
Place: Clemson University, Clemson, South Carolina
For Information: Dr. Samuel F. Hulbert, Dean of Engineering, Tulane University, New Orleans, Louisiana 70111

May 6-9

The Treatment of Coronary Syndromes
Place: Atlanta, Georgia
For Information: Miss Mary Anne McInerney, Director, Department of Continuing Education Programs, American College of Cardiology, 9650 Rockville Pike, Bethesda, Maryland 20014

Items submitted for listing should be sent to: **WHAT WHEN? WHERE?**, P. O. Box 8248, Durham, N. C. 27702 by the 10th of the month prior to the month in which they are to appear.

News Notes from the—

**UNIVERSITY OF NORTH CAROLINA
DIVISION OF HEALTH AFFAIRS**

anis Newton, assistant director for Continuing Education in Health Sciences, has been elected to the steering committee of the Continuing Education for Professions Section of the Adult Education Association of the U.S.A.

The major concern of the section this year is the implications of mandatory continuing education for professions.

* * *

r. J. Wilbert Edgerton has been elected to head national professional organizations. He is president of Division 27, American Psychological Association, and chairman of the Mental Health Section of the American Public Health Association.

Division 27 is composed of community psychologists throughout the world.

Edgerton is professor in the departments of psychology and psychology.

* * *

r. R. W. Penick, a 1968 graduate of the UNC School of Public Health, received the Sidney S. Chipman Award Nov. 16 at ceremonies in Carrington on the Chapel Hill campus. Dr. Penick, director of public health at the Greenville-Pickens District Health Department in South Carolina, was cited for work in developing one of the most outstanding community health programs in the country.

The Chipman Award was established in 1970 to recognize the contributions of Dr. Sidney S. Chipman, founder of the UNC Department of Maternal and Child Health in 1950 and chairman until 1967. Recipient of the award must be a graduate of the program who has made outstanding contributions in the field of maternal and child health.

* * *

r. C. Arden Miller of the UNC School of Public Health has been elected president-elect of the 50th Annual American Public Health Association (APHA).

Miller was elected by the governing council of the Association's annual meeting in San Francisco.

A professor of Maternal and Child Health, Dr. Miller is former vice chancellor for health sciences at the University of Kansas. He is also a pediatrician and former dean and president of the University of Kansas Medical Center.

Miller is the second national president to come from the UNC School of Public Health in the past 40 years. Dr. Margaret Dolan, former president and chairman of the department of public health at the University of Kansas, was president in 1972-73.

Dr. Kenneth M. Brinkhous stepped down as chairman of the UNC School of Medicine's Department of Pathology in October. He had held the position since 1946. He became an Alumni Distinguished Professor of Pathology in 1961.

Dr. Brinkhous was cited for his outstanding contributions to biomedical research, his service to medicine, his training of medical students and his leadership in developing national and international research programs.

* * *

Barbara B. Germino was promoted to associate professor in the School of Nursing. Charles Harper was promoted to associate professor in the School of Public Health.

* * *

Dr. Ralph H. Boatman, administrative dean of the UNC Office of Allied Health Sciences, has been elected secretary of the American Society of Allied Health Professions (ASAHP).

Boatman is immediate past chairman of the ASAHP's Council on Baccalaureate and Higher Degrees. The Society changed its name and reorganized its councils at its November meeting. Previously it was the Association of Schools of Allied Health Professions.

News Notes from the—

DUKE UNIVERSITY MEDICAL CENTER

Duke and Cabarrus Memorial Hospital in Concord are engaged in a joint new program aimed at improving and expanding health care for the people served by the hospital and providing continuing education for doctors on the hospital staff.

The one-year affiliation may lead to a broader long-term arrangement. This could include the channeling of Duke interns, residents and fourth-year medical students, particularly those interested in family practice, through a period of training under senior physicians at Cabarrus.

About 15 doctors from Duke's departments of medicine, surgery, pediatrics and obstetrics-gynecology have been commuting to Concord weekly for one- or two-day visits.

While the primary focus during the initial year is to provide continuing education for the Cabarrus staff, Duke hopes the affiliation will provide the basis for future training of young doctors and senior medical students in a community hospital setting and perhaps lead to affiliations between Duke and other hospitals in the state.

* * *

Dr. Daniel C. Tosteson, chairman of physiology and pharmacology, is the new chairman of the Association of American Medical Colleges (AAMC).

Tosteson is the first representative of the AAMC's Council of Academic Societies to be chosen chairman, the organization's highest elective office. He said he believes the development shows that the AAMC is moving to represent more effectively all segments of academic medicine, including the professional educators who comprise faculties of schools of medicine.

A Harvard graduate (M.D. '49), Tosteson has been department chairman at Duke since 1961. In 1971 he was named James B. Duke Professor of Physiology.

* * *

Dr. Joseph C. Farmer, Jr., assistant professor of surgery, and Dr. David F. Paulson, assistant professor of urologic surgery and director of urologic research, were inducted as new Fellows of the American College of Surgeons at the 59th Annual Clinical Congress in Chicago.

* * *

A researcher at Duke has been awarded a March of Dimes grant to study some of the genetic and biochemical aspects of connective tissue diseases.

The one-year, \$16,500 grant has been given to Dr. Byron D. McLees, assistant professor of medicine, under a program designed to enable young scientists to start their own research projects on birth defects.

* * *

At a special ceremony, Duke's Orthopaedic Outpatient Clinic was renamed for Dr. Lenox D. Baker, retired Duke surgeon who served as North Carolina's first Secretary of Human Resources.

Baker, who was Duke's first medical student and the first doctor to graduate after completing a full four-year course, was chief of orthopaedic surgery from 1937-67 and was instrumental in establishing and operating the N. C. Cerebral Palsy Hospital which also has been renamed for him.

* * *

In another special ceremony, Dr. Ewald D. Busse, chairman of psychiatry at Duke for 20 years, was honored with a dinner and scientific program, which included presentation of a portrait of Busse to the medical center.

* * *

Dr. Hiroshi Nagaya, assistant professor of medicine, and Dr. C. E. Buckley III, associate professor of medicine, assistant professor of microbiology and immunology, and director of the Allergy-Immunology Laboratory, attended the International Congress of Rheumatology in Kyoto, Japan, and the International Congress of Allergology in Tokyo.

* * *

About 100 doctors from throughout the state attended the joint annual meeting of the N. C. Society of Internal Medicine and the regional chapter of the American College of Physicians at Duke in December.

The subject for a day-long scientific program was

Rondomycin (methacycline HCl)

CONTRAINDICATIONS: Hypersensitivity to any of the tetracyclines

WARNINGS: Tetracycline usage during tooth development (last half of pregnancy to years) may cause permanent tooth discoloration (yellow-gray-brown), which is common during long-term use but has occurred after repeated short-term courses. Enamel hypoplasia has also been reported. **Tetracyclines should not be used in the group unless other drugs are not likely to be effective or are contraindicated.**

Usage in pregnancy: (See above **WARNINGS** about use during tooth development.) Animal studies indicate that tetracyclines cross the placenta and can be toxic to the developing fetus (often related to retardation of skeletal development). Embryotoxicity also been noted in animals treated early in pregnancy.

Usage in newborns, infants, and children: (See above **WARNINGS** about use during tooth development.)

All tetracyclines form a stable calcium complex in any bone-forming tissue. A decrease in fetal bone growth rate observed in premature given oral tetracycline 25 mg/kg every 6 hours was reversible when drug was discontinued.

Tetracyclines are present in milk of lactating women taking tetracyclines.

To avoid excess systemic accumulation and liver toxicity in patients with impaired function, reduce usual total dosage and, if therapy is prolonged, consider serum level determinations of drug. The anti-anabolic action of tetracyclines may increase BUN, not a problem in normal renal function, in patients with significantly impaired function higher tetracycline serum levels may lead to azotemia, hyperphosphatemia, and acidosis.

Photosensitivity manifested by exaggerated sunburn reaction has occurred with tetracyclines. Patients apt to be exposed to direct sunlight or ultraviolet light should be advised, and treatment should be discontinued at first evidence of skin erythema.

PRECAUTIONS: It superinfection occurs due to overgrowth of nonsusceptible organisms including fungi, discontinue antibiotic and start appropriate therapy.

In venereal disease when coexistent syphilis is suspected, perform darkfield examination before therapy, and serologically test for syphilis monthly for at least four months.

Tetracyclines have been shown to depress plasma prothrombin activity; patients receiving anticoagulant therapy may require downward adjustment of their anticoagulant dosage.

In long-term therapy, perform periodic organ system evaluations (including renal, hepatic).

Treat all Group A beta-hemolytic streptococcal infections for at least 10 days.

Since bacteriostatic drugs may interfere with the bactericidal action of penicillin, giving tetracycline with penicillin.

ADVERSE REACTIONS: Gastrointestinal (oral and parenteral forms): anorexia, nausea, vomiting, diarrhea, glossitis, dysphagia, enterocolitis, inflammatory lesions (with local overgrowth) in the anogenital region.

Skin: maculopapular and erythematous rashes, exfoliative dermatitis (uncommon); photosensitivity is discussed above (See **WARNINGS**).

Renal toxicity: rise in BUN, apparently dose related (See **WARNINGS**).

Hypersensitivity: urticaria, angioneurotic edema, anaphylaxis, anaphylactoid purpura, pericarditis, exacerbation of systemic lupus erythematosus.

Bulging fontanels, reported in young infants after full therapeutic dosage, have subsided rapidly when drug was discontinued.

Blood: hemolytic anemia, thrombocytopenia, neutropenia, eosinophilia.

Over prolonged periods, tetracyclines have been reported to produce brown-black microscopic discoloration of thyroid glands, no abnormalities of thyroid function studies known to occur.

USUAL DOSAGE: Adults—600 mg daily, divided into two or four equally spaced doses. More severe infections, an initial dose of 300 mg followed by 150 mg every six hours. 300 mg every 12 hours. Gonorrhea. In uncomplicated gonorrhea, when penicillin is contraindicated, Rondomycin (methacycline HCl) may be used for treating both male and females in the following clinical dosage schedule: 900 mg initially, followed by 300 mg q.i.d. for a total of 5.4 grams.

For treatment of syphilis, when penicillin is contraindicated, a total of 18 to 24 g of Rondomycin (methacycline HCl) in equally divided doses over a period of 10 to 14 days should be given. Close follow-up, including laboratory tests, is recommended.

Eaton Agent pneumonia: 900 mg daily for six days.

Children:—3 to 6 mg/lb/day divided into two to four equally spaced doses.

Therapy should be continued for at least 24-48 hours after symptoms and fever subsided.

Concomitant therapy: Antacids containing aluminum, calcium or magnesium interfere with absorption and are contraindicated. Food and some dairy products also interfere. Give one hour before or two hours after meals. Pediatric oral dosage forms should be given with milk formulas and should be given at least one hour prior to feeding.

In patients with renal impairment (see **WARNINGS**), total dosage should be decreased by reducing recommended individual doses or by extending time intervals of doses.

In streptococcal infections, a therapeutic dose should be given for at least 10 days.

SUPPLIED: Rondomycin (methacycline HCl) 150 mg and 300 mg capsules, syrup containing 75 mg/5 cc methacycline HCl.

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medicine, has been elected president-elect of the Forsyth County Medical Society. Dr. James F. Toole, professor and chairman of the Department of Neurology, has been elected vice chairman of the society. Dr. C. Douglas Maynard, professor of radiology, has been elected a delegate to the North Carolina Medical Society. The Forsyth County Medical Society's current president is Dr. M. Frank Sohmer, Jr., clinical instructor in medicine at the Bowman Gray School of Medicine.

* * *

Dr. David R. Mace, professor of family sociology, spoke on various aspects of marriage and family during a month of speaking engagements throughout the United States. His topics included, "The Development of Interpersonal Potential in Married Couples," "A New Preventative Approach to Marital Disharmony," "Our Professional Responsibility for the Prevention of Marriage and Family Breakdown," "Marriage—Its Present Status and Future Prospects," "Marriage Enrichment—Its Procedures and Potentials," "Help Families to Help Themselves and Each Other" and "A Prevention to Malfunctioning Families Through Marriage Enrichment."

* * *

Dr. George Podgorny, clinical instructor in surgery, was a panel member on emergency care at the Ontario Medical Society meeting on emergency medical care Oct. 5 in Toronto, and represented the

North Carolina chapter of the American College of Emergency Physicians at the annual college assembly in Dallas.

* * *

Dr. James F. Toole, professor and chairman of the Department of Neurology, spoke on "Evolution of Concepts of Ethical Standards" on Nov. 5 to the Council on Academic Societies of the American Association of Medical Colleges in Washington, D. C.

NEW FDA PROPOSAL ON X-RAY EQUIPMENT

The Food and Drug Administration proposed action on Dec. 3, 1973 (1) to require that equipment manufactured after the August 1, 1974, effective date of the diagnostic x-ray standard shall contain only parts certified for compliance and (2) to promote the upgrading of existing equipment to meet the standard's performance requirements for patient protection.

The proposals were published in the *Federal Register* December 3, as an addition to policy provisions of Radiation Control for Health and Safety Act regulations. The addition would replace policies proposed last February 28. These would have included the requirement that used x-ray equipment be refurbished, rebuilt, or reassembled and sold after

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GRAENUM R. SCHIFF, M.D.

August 1, 1974, would have to comply with the standard for new equipment.

FDA's proposed new policy declaration would prevent the assembly and installation of new systems having a combination of components that meet the standard and those that do not. The regulations, as presently written, could be interpreted as permitting certified and uncertified components to be combined during the assembly of a new system. Such a mixture might not have the public health advantages of an x-ray system composed entirely of certified components.

The upgrading of existing equipment would be achieved under two other provisions of the new policy proposal. One would require that an x-ray system made before August 1, 1974, but repaired or modified by installation of a certified component, would thereafter have to use only certified replacement components. The other provision would prohibit the assembly of uncertified components into systems moved, reassembled, and sold after August 1,

1979—five years after the standard became effective. Components not made under the standard would have to be replaced in such reassembled systems.

The five-year grace period for application of the standard to used diagnostic x-ray equipment would allow time for adequate inventories of certified components to be produced. The period, furthermore, is compatible with medical profession estimates of the usual time it would take certified equipment to move from hospital radiology departments and other high workload facilities into used x-ray machine markets.

During the five years allowed for relocating and selling equipment with uncertified components, FDA, in order to protect the public health, could take action against any equipment found to be defective.

The February 28 proposal was opposed by State and local radiation protection agencies as well as physician organizations and individual doctors. Many of the agencies reported that components complying with the standard could not be used with some of the x-ray systems subject to their registration.

Month in Washington

Two more major national health insurance proposals have been thrown into the Congressional hopper, bringing the total to eight with at least two more waiting in the wings, including that of the Administration.

Chairman Harley O. Staggers (D-W. Va.) of the House Commerce Committee has introduced his own national health insurance proposal (NHI), saying hearings will be held on his bill in the coming year.

The second new NHI proposal came from Senate Republican leader Hugh Scott (R-Pa.) and Charles Percy (R-Ill.).

Staggers' National Comprehensive Health Benefits Act of 1973 would provide comprehensive health care benefits and complete protection against the costs of catastrophic illness to all. It would be financed by a combination of contributions from employers, the federal government and individuals, based on income. The federal funds are for health insurance and catastrophic illness benefits for the poor and near-poor.

The introduction came shortly before hearings on NHI by the Commerce Subcommittee on Public Health and Environment.

It is the first major NHI proposal to be referred

to the Interstate and Foreign Commerce Committee rather than the Committee on Ways and Means, Staggers noted, adding that it is the first NHI proposal by a chairman of a major committee in the House.

Major features of the proposal, as described by Staggers:

- a strong role for state governments in the development and administration of the program;
- incentives for the creation and use of Health Maintenance Organizations;
- a six-year transitional period for orderly development;
- the use of existing private health insurance carriers for administration of the insurance provisions;
- and the fact that the program builds on, rather than federalizing, the existing health care system.

The bill provides that newly created State Health Commissions (SHC's) would be responsible for the actual administration of much of the program, including standard setting and quality control, assisting in the development of Health Maintenance Organizations (HMO's), and administration of some of the insurance provisions. Existing private health insurance carriers would be used to underwrite most of the

legislation's insurance benefits. The development and use of HMO's would be encouraged through additional direct developmental assistance and through a ten percent federal subsidy of HMO premiums.

Within two years of enactment all aged, low income and unemployed individuals and families, would be provided coverage for basic health services. Within four years of enactment, all individuals and families would be provided coverage for basic health services and the costs of catastrophic illness. Within seven years of enactment, all individuals and families would be provided coverage for comprehensive health care benefits and the costs of catastrophic illness.

Senator Scott said his two-part "Health Rights Act" would provide for in-patient protection for all persons suffering major illness, and would set up an out-patient health maintenance insurance plan. It would replace both the medicare and medicaid programs now in effect. Scott added that he believed his bill was "must legislation" for this session of Congress "because its goal is to serve every American at a critical time."

Under the Scott-Percy Health Rights Act, both the in-patient and out-patient plans would be administered by insurance carriers or other public or private agencies on a regional basis, under contract with the newly created Office of Health Care within the Department of Health, Education and Welfare.

The in-patient, "major illness" protection differs from traditional catastrophic plans by covering all costs above each family's health cost ceiling, which is determined by a formula taking into account both family income and family size. Money for the plan would be financed in part through the present health insurance portion of Social Security payroll taxes and in part through general revenues.

The out-patient plan would be financed in part through family premium payments which would be supplemented in whole or part with federal payments for low-income families. Employers could arrange to finance all or part of their employees' premiums.

The Act would also establish a two-year, Presidentially appointed "Health Delivery Committee" to study the current and long-range needs for medical personnel and facilities. It would make recommendations to the President and Congress.

* * *

The American Medical Association has asked the Congress to reject proposed legislation that would restrict the Food and Drug Administration's authority over food supplements.

In testimony before the House Commerce Subcommittee on Health and Environment, C. E. Butterworth, Jr., MD, Chairman of the AMA's Council on Foods and Nutrition, said the FDA's actions "are based upon sound scientific evidence and are clearly in the public interest."

Under new FDA regulations, U. S. government

recommended daily allowances (RDA's) have been established that permit the inclusion of 19 essential vitamins and/or minerals in products to be marketed as dietary supplements. The RDA's are based on those formed by the National Academy of Sciences and reflect the most current scientific judgments on the subject," said Dr. Butterworth.

Ingredients with no recognized nutritional value would be excluded from dietary supplements.

"There is no scientifically acceptable evidence to support the use of bioflavonoids, rutin, inositol and other similar ingredients," said the witness. "It is my opinion also that the quantities of vitamins included in mixtures for dietary supplementation should furnish daily an amount which approximately fulfills but does not greatly exceed the recommended dietary allowances," Dr. Butterworth testified. Inclusion of excessive amounts of fat-soluble vitamins A and D can be harmful, and "is scientifically unwarranted and potentially dangerous," he said.

Dr. Butterworth said: "It clearly would not be in the public interest to enact legislation virtually eliminating the authority of the Secretary (HEW) to control the kinds and amounts of ingredients in dietary supplements and other foods for dietary use. The current regulations promote safety, and provide full information to consumers about such products and this information will enable them to make decisions based on scientifically acquired data."

* * *

Legislation liberalizing tax treatment of retiree savings by the self-employed seems to be moving closer to congressional enactment in the next Session.

The House Ways and Means Committee has tentatively approved the Senate provision allowing self-employed people such as lawyers, dentists and physicians to claim tax deductions on \$7,500 a year, 15 percent of income, for sums placed in qualified pension plans. This compares with the previous Keogh limit of \$2,500 or 10 percent of income.

The threat of a strict limitation on pension tax deferrals in corporations, including professional service corporations, appears to have diminished. The Ways and Means Committee in general accepted the principle in the Senate bill of a \$75,000 annual limit on retirement benefit plans (so-called defined benefit plans) and on others (defined contribution plans which included profit-sharing, money purchase, etc.) of a retirement benefit not to exceed 100 percent of the high three years of average compensation.

Ways and Means must still take a final vote and also work out with the House Education and Labor committee an agreement on the form the over-50 legislation—a sweeping pension reform measure—will take when presented on the House floor. Defeated in Ways and Means was a move by labor, an arch enemy of the Keogh provision, to reduce tax deferral to a maximum of \$5,000 per year.

President Nixon is correct in his statement that the temperatures in the mid-60s are, in some ways, healthier than temperatures in the mid-70s, according to William Barclay, MD, Assistant Executive Vice President for Scientific Affairs, American Medical Association.

Heating the interior of homes and offices during the winter removes moisture from the air. The higher the temperature, the drier the air. Air with little moisture aggravates bronchial and other respiratory problems. It can contribute to dry throat and nose, coughs and dry skin.

The respiratory system doesn't cope well with the sudden changes in temperature. Moving from an overly warm room into outside cold affects the body adversely, causing coughs and respiratory problems. The body adjusts to temperature changes gradually. We feel the cold more acutely on the first cold day of the fall than in January. We do not adapt well to abrupt temperature changes.

There are no major health advantages inherent in keeping inside temperatures somewhat lower, but there are minor advantages that add to comfort and well-being during the winter."

* * *

President Nixon has signed into law a three-year, \$5 million bill to help set up emergency medical systems around the nation.

The bill authorizes grants and contracts for feasibility studies, planning, establishment, operation and expansion of emergency medical systems (EMS) as well as research and training. Rep. Tim Lee Carter, (R-Ky.) said in House debate it would assist communities throughout the nation to develop and improve their emergency medical services systems and "contribute directly to saving tens of thousands of lives each year."

President Nixon had criticized the bill in a veto earlier this year, contending that existing federal and state programs are adequate to handle the problem. The veto led to a major confrontation with Congress last September in which the Administration lost when the House failed by a narrow margin to muster the required two-thirds vote.

The bill increases from 50 percent to 75 percent the federal share of grants for emergency programs and earmarks 20 percent of grants for rural areas. The Administration's prime objection to the earlier bill was an amendment ordering that all public health service hospitals be kept open. The EMS law does not contain this provision. However the PHS hospitals were kept alive by a rider to a military appropriations bill that was subsequently signed into law.

* * *

The White House has said that it plans to designate enough radio frequencies for emergency medical service to serve the entire country.

Clay T. Whitehead, director of the White House's Office of Telecommunications Policy, says this will be a vital first step in giving American communities the kind of integrated emergency medical services they need to save thousands of lives a year among persons stricken by heart attacks and strokes or injured in accidents. Many such persons now die because they do not get adequate emergency care before they reach a hospital.

Estimates of the number of lives that could be saved each year if all regions of the country had adequate emergency care systems range from 60,000 to more than 100,000.

Mr. Whitehead noted that a few cities already had efficient systems including two-way communication between ambulance and hospital and radio equipment for sending vital data on the patient's condition from the scene of the emergency to doctors at a hospital. For most American communities, he said, such arrangements are still nothing more than science fiction.

Dr. Charles C. Edwards, Assistant Secretary for Health in the Department of Health, Education and Welfare, said the department was putting a high priority on efforts to develop an efficient emergency medical system throughout the United States. How much of the effort should be Federal and how much locally initiated is under study, he said.

The Administration plan calls for allocating 38 radio frequencies for emergency medical use throughout the United States. Mr. Whitehead said 22 were already available, but on a much less standardized basis. Some of the others are now used by the Department of Defense and other Federal agencies. Still others are used for highway callboxes, ski patrols and the like. A few are not allocated.

* * *

The American Medical Association has awarded a plaque to David Kindig, MD, in recognition of his "outstanding and dedicated service in implementing the goals and objectives of the National Health Service Corps (NHSC)."

Dr. Kindig played a key part in launching the NHSC program of sending PHS physicians into physician-shortage areas where help is requested by the local and state medical societies. In receiving the award, the youthful physician said the cooperation of the AMA and of the nation's local and state medical societies has "been unique and made the program a success."

Presenting the award, at a Washington, D. C., lunch Richard Palmer, MD, vice chairman of the AMA Board of Trustees, said the AMA has been firmly behind the NHSC program. He pointed to the AMA's "project USA" program in which the AMA provides physicians to spell PHS physicians who are on vacation or ill.

Book Reviews

Standard First Aid and Personal Safety. The American National Red Cross, First Edition, 268 pages. Price \$1.95, Garden City, New York: Doubleday & Co., Inc., 1973.

Advanced First Aid & Emergency Care. The American National Red Cross, First Edition, 318 pages. Price \$2.50, Garden City, New York: Doubleday & Co., Inc., 1973.

Dr. Warren Cole was chairman of the Ad Hoc Committee of the Division of Medical Sciences, National Academy of Sciences, which gave authoritative advice and guidance for 1973 editions of these American National Red Cross textbooks for use in their popular First Aid instruction program.

The books are up to date in content, concisely written and presented, appropriately illustrated with colored drawings, and thoroughly practical in approach.

The standard volume is written in outline style, which may make learning easier for the beginning first aid student, and puts emphasis on prevention of accidents.

The advanced volume was prepared for policemen, firemen, ambulance attendants, and others whose jobs make them responsible for giving emergency care. It includes more instructions on use of equipment readily available to them, such as half-ring splints and stretchers, techniques of methods of extricating victims from automobiles and closed spaces, and a chapter on emergency childbirth.

Otherwise the general contents, instructions, and illustrations are the same, covering wounds, shock, respiratory emergencies and resuscitation, poisonings, drugs, fractures, splints, dressings, and transportation.

Perhaps the conduct of an advanced course differs enough from that of the standard course to justify the printing of separate texts with almost identical contents. In my opinion the advanced volume is not too advanced for a beginning first-aider, and I would recommend this one for all. Each volume, however,

is complete in itself, and can serve admirably as a home text and reference on this important subject for anyone, whether he takes a formal course or not.

LOUIS SHAFFNER, M.D.

Review of Medical Physiology. 6th Edition, 577 pages. W. F. Ganong, M. D., Los Altos, California: Lange Medical Publications, 1973.

Every two years Ganong's *Review of Medical Physiology* is revised, partially reset, re-covered and released for use by freshmen medical students as a short text and practicing physicians as an outline review of physiological processes. The current 6th edition has been changed very little from the 5th edition, which was altered only slightly from the 4th edition, etc. Although certain sections have been updated such as the discussions on cyclic AMP and Calcitonin, the text and illustrations remain largely as they were in previous editions.

In the past, this book has been used primarily as an *introductory* text for the first-year course in medical physiology. As such it does not present any subject in detail (e.g. the two short paragraphs on the prostaglandins) and has omitted all controversy. By not representing all views of current debate, the text tends to appear somewhat dogmatic.

Future use of this book as a medical student text may be limited by its classical physiology orientation and its assumption of a prior working knowledge of anatomy and biochemistry. With the present curricula emphasizing the time integration of all basic science material, the utility of this type of text is diminished in these arenas. It is, however, recommended to practicing physicians and others who, having studied physiology under the old block system, desire a superficial review outline of medical physiology.

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In Memoriam

Glenn Raymer Frye, M.D.

Glenn Raymer Frye was born on a farm in Iredell County, N. C. on April 29, 1894, to Eli Davidson Frye and Mary Jane Raymer Frye. He was the youngest of twelve children of whom a brother, Hal Frye, and a sister, Mrs. J. Watt Summers, are still living.

He attended the local schools and entered Lenoir Rhyne College in 1913, graduating in 1917, with an A.B. Degree. While a student there, he was a winner of the Junior Oratorical Debate Medal, President of the student body and of the senior class, business manager of the college annual and played varsity baseball for three years.

In 1917, he entered The University of North Carolina Medical School, then a two year school, and while there enlisted in the Students Army Training Corps. He later entered Jefferson Medical College of Philadelphia, graduating in 1921 with an M.D. Degree. In 1921-22, he interned at the Presbyterian Hospital in Philadelphia, and on August 1, 1922, began the practice of medicine in Hickory, North Carolina.

On November 22, 1922, he married Barbara Kathryn Aderholdt. They have three wonderful daughters, Mary Kathryn (Mrs. Samuel Hemphill), Mrs. Martha Terry, and Ruth (Mrs. Hugo Deaton), also eleven grandchildren.

Initially, in Hickory, Dr. Frye was associated with Dr. Jake Shuford, Sr., who founded the Richard Baker Hospital, a private hospital of 14 beds. In 1929, Dr. Frye became chief surgeon and five years later purchased the hospital. Since that time there have been numerous additions until a capacity of 119 beds was reached in 1968. During these years the two names, Richard Baker Hospital and Dr. Glenn R. Frye became synonymous. No truer word was ever written, "An institution is but the lengthened shadow of one man."

In 1931, Dr. Frye was admitted as a Fellow of the American College of Surgeons, later a Fellow of the Southeastern Surgical Congress and a Diplomat of the American Board of Surgery. In 1948, Lenoir

Rhyne College conferred on him the Degree of Honorary Doctor of Laws. He served on the Board of Trustees and in 1955, was general chairman of the Building Campaign. He and Mrs. Frye have established a professorship in chemistry and he was honorary chairman of the Fund Raising Campaign.

Next to his family and his hospital, Dr. Frye loved his church. He was a member of the Holy Trinity Lutheran Church and vice-chairman of the church council. In October 1948, he was elected to the Board of World Missions of the United Lutheran Church in America and served in this capacity for twenty years. He was also a delegate to two national conventions of his church.

Regarding his community activities, Dr. Frye was a past president of the Hickory Rotary Club, The Catawba County Medical Society, The Catawba Valley Executives Club and the Hickory Community Concert Association. In 1951, he was co-chairman of The Hickory Community Chest and a past director of Board of Health of Catawba, Lincoln and Alexander counties. The Medical Foundation of the University of N. C., The Medical Advisory Committee of the Catawba County Chapter of the American Red Cross and for many years he was a director of Sips Orchard Home.

From October 15, 1940, to March 31, 1947, he served his country by being the Chief Medical Examiner — Selective Service, Hickory Township.

Dr. Frye was dean of the Hickory physicians and on October 8th of last year (1972) a special observance was held at Lenoir Rhyne College honoring him for his more than 50 years of service to the community. The Frye Scholarship Fund at Lenoir Rhyne College, endowed by the Hickory Rotary Club and the Kiwanis Club was established at that time.

Since then it was business as usual for Dr. Frye up until shortly before September 1 when, after a brief illness, he died September 9, 1973, in the hospital where he had been associated for more than half a century.

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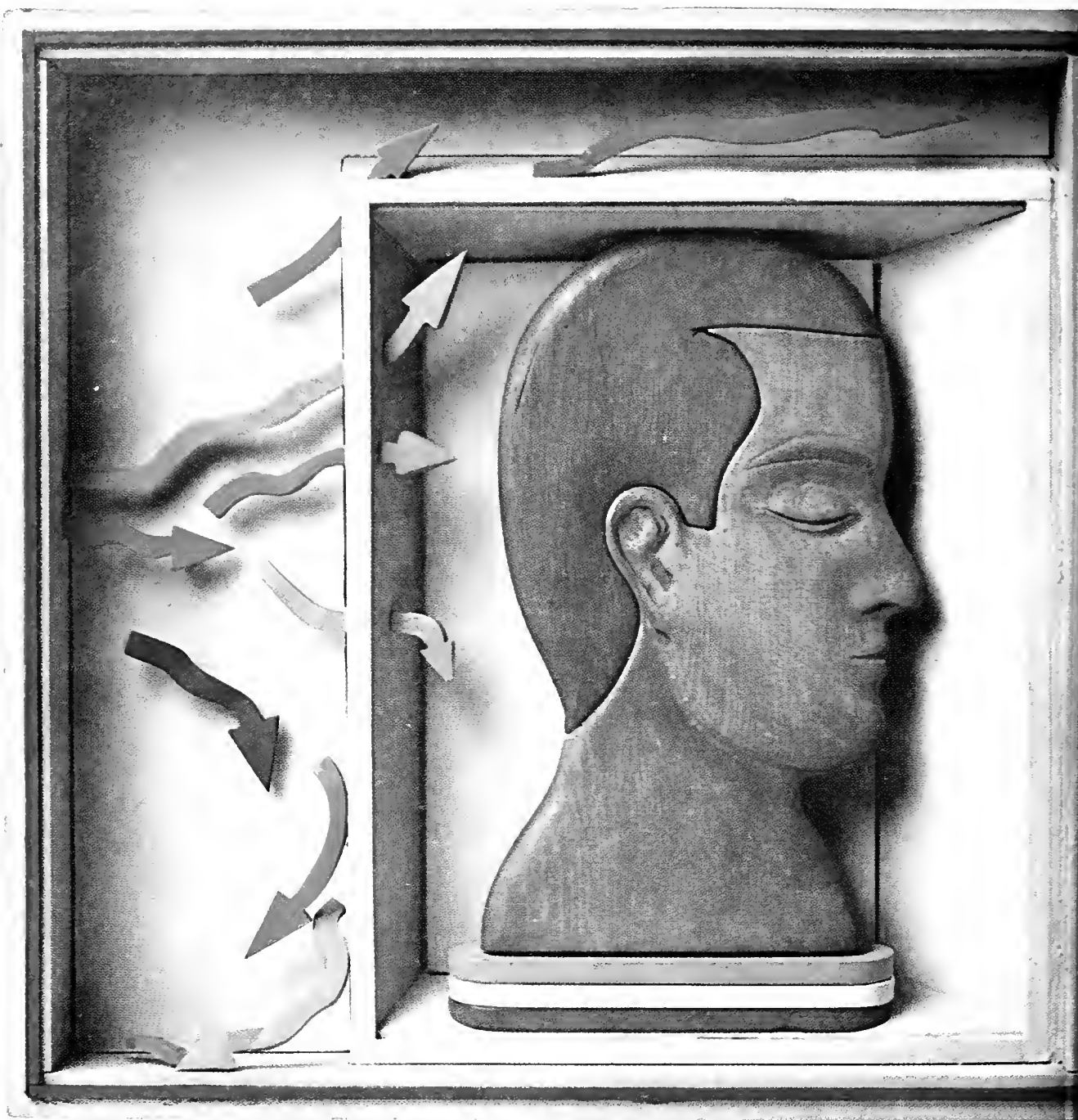
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NORTH CAROLINA

Medical Journal

THIS ISSUE: Medical and Surgical Complications of Therapeutic Termination of Pregnancy, David A. Evans, M.D., and John P. Gusdon, M.D.; The Tail is Wagging the Dog, Bernard A. Wansker, M.D.; A Community of Care, Peter James

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PRESIDENT'S NEWSLETTER

MEDICAL SOCIETY OF THE STATE OF NORTH CAROLINA

No. 9

February 8, 1974

The moves and counter moves on the PSRO front are coming in such bewildering speed that it is hard to keep up. I will enumerate just a few high spots:

- (1) Out of the blue in mid-January, the Secretary of HEW, Mr. Weinberger, put out a proposed regulation making pre-hospital admission approval for all Medicare and Medicaid patients mandatory by thirty days after publication in the Federal Register.
- (2) On January 25th, the President of the American Medical Association, Dr. Russell B. Roth, in a press release announced that the American Medical Association will take Secretary Weinberger to court if he doesn't cancel this ridiculous regulation.
- (3) On January 23rd, Dr. Frank Sohmer, President of our North Carolina Medical Peer Review Foundation, Inc., Congressman Richardson Preyer, Mr. John Anderson and Mr. Henry Mitchell, our Legal Counsel, personally delivered North Carolina's official protest against four PSRO's for the State. Coincidentally, great credit and thanks go to Congressman Richardson Preyer for his untiring efforts in our behalf and great cooperation in helping present our case to Dr. Henry Simmons, the head of the PSRO office. They reported cordial but a non-rewarding reception. However, in the same press release mentioned above, Dr. Ross announced that the AMA will go to court with all states wanting to protest the geographic boundary decisions. Along with Mr. Bill Hilliard, our Executive Director, on January 25th, I attended a meeting with representatives of nearly all the rebelling states where tentative agreement was reached to join together in a common suit with the help of the AMA.
- (4) Copies of our protest with a covering letter from me went to all of the North Carolina delegation in Washington and they have nearly all responded with notes of cooperation.

In the meantime back home in North Carolina, the political winds are slowly reaching gale proportions. Now is the time to get down to bedrock. The President of the New York State Medical Society asked his legislators why doctors do so poorly in the political arena. The answer was unanimous, "You doctors don't contribute to our campaign. Put your money where your mouth is." In addition to money you should also let the state legislator of your choice know that you not only contributed to his campaign but that you are also willing to ring doorbells and work at the precinct level in his behalf. This is the only way we will ever

improve our political effectiveness. All such activity should also be accompanied by membership in both the national AMPAC organization as well as the North Carolina MedPac organization.

In this hectic environment, our State Medical Society's Legislative Committee with its Chairman, Dr. David Bruton; our attorney, Mr. John Anderson; and our Legislative Staff Representative, Steve Morrisette, are working feverishly staying on top of the bills, committee meetings, and actions of the state legislature related to health. Governor Holshouser's State of the State Message emphasized the importance of upcoming health legislation, and we were very pleased that he came out loud and clear in supporting the Board of Governors of the Greater University in their AHEC program. The stand your Governor has taken on these matters is in basic agreement with that of the State Medical Society. It will be sheer tragedy for the future of medical education in this state if politicians succeed in getting higher education back into partisan politics.

The annual State Medical Society Leadership Conference was for the first time held in Raleigh on the 1st and 2nd of February. This use of our new headquarters building along with the provocative program arranged and provided by our Public Relations Committee proved to be a great success, so much so that it was decided to use the same format in 1975.

This was indeed an eventful weekend, for not only did the Board of North Carolina Peer Review Foundation, Inc., have a meeting but also as has been the custom following the Leadership Conference, so did your Executive Council.

The shock waves stemming from these meetings were so numerous and of such amplitude that space in this Newsletter forbids enumeration. Suffice it to say, that the shocks will be reaching you in the relatively near future.

Like all other institutions these days, our society is having to tighten its financial belt. Currently, you get this Newsletter twice -- once in the mailing with the Public Relations Bulletin and once as a page in the State Medical Journal. I would like opinions as to the wisdom of distributing it only once and if so by eliminating which method of getting it to you.

Sincerely yours,

A handwritten signature in cursive script, reading "George G. Gilbert".

George G. Gilbert, M.D.
President

Medical and Surgical Complications of Therapeutic Termination of Pregnancy

David A. Evans, M.D.* and John P. Gusdon, M.D.

FROM January 1970 to October 1971, therapeutic termination of pregnancy was performed upon approximately 550 patients at the North Carolina Baptist Hospital. Of these patients' records, 536 were extensively reviewed to determine the extent of our complications with these procedures. Recent reports from other institutions have shown an overall morbidity rate, in combined first and second trimester terminations, to be nearly 13.5 percent. However, these same reports showed that, in their large series, the major complications of all stages of termination were a surprisingly low 1.7 percent.¹

Our own data, analyzed for all complications (major and minor), either compiled from the record or communicated by the patients at their follow-up examinations, showed an overall complication rate of 20 percent. If one carefully excludes all minor complications, the rate drops to 11.7 percent. Table 1 gives the total breakdown according to procedure, trimester, and complications (major or minor).

There was a nearly equal division

between clinic and private patients. Two hundred and forty-one patients were managed by the resident staff, and 295 were managed by the attending physicians.

MATERIALS AND METHODS

Therapeutic abortion medical records from January 1970 to October 1971 were obtained from the North Carolina Baptist Hospital in Winston-Salem, North Carolina. Each chart was reviewed completely, and pertinent data were analyzed.

Major complications of the first trimester included: (a) hemorrhage of greater than 500 ml of blood; (b) infection with febrile morbidity (defined as a temperature above 100.4 F which persists for more than

24 hours); and (c) uterine perforation.

Complications of the second trimester included hemorrhage, infection, and failure of the primary induction, requiring a second procedure (in cases of saline-induced abortion).

In the category of major complications, we have included patients who were readmitted to the hospital for observation, as well as patients who required a second procedure.

RESULTS

Table 1 is a composite of all trimesters and all procedures. It shows the differential between all complications and major complications.

Table 2 shows the complications

Table 1
Complications of Therapeutic Termination of Pregnancy
North Carolina Baptist Hospital

January 1970 - October 1971

536 CASES*

Trimester	Procedure	Number of Cases	All Complications Number	Percent	Major Complications Number	Percent
First	D & C—Suction	346	39	11.3	18	5.2
Second	Saline	127	36	28.3	27	21.3
	Hysterotomy and tubal ligation	63	32	50.8	18	28.5
TOTAL	All Procedures	536	107	20.0	63	11.7

* 295 private, 241 clinic.

Read before the Annual Session, North Carolina Medical Society, Pinehurst, May 19-23, 1973. From the Department of Obstetrics and Gynecology, the Bowman Gray School of Medicine, Wake Forest University, Winston-Salem, N. C. 27103.

*Present address: Monroe Women's Clinic, Monroe, N. C. 28110.

Table 2
Complications of D and C—Suction Abortions
North Carolina Baptist Hospital Study

January 1970 - October 1971

346 CASES*

Complication Category	All Complications Number	Percent	Major Complications Number	Percent
Postpartum bleeding	13	3.8	10	2.9
Infection	18	5.2	0	0.0
Perforation	8	2.3	8	2.3
TOTAL	39	11.3	18	5.2

* 222 private, 124 clinic.

of D and C suction abortions in 346 cases. Of these cases, 3.8 percent were complicated by some type of postpartum bleeding; however, excluding all cases except those having an estimated blood loss greater than 500 ml, only 2.9 percent (10 cases) had bleeding complications of the first trimester.

In the original survey, 18 patients (5.2 percent of the total) had some type of infection or febrile morbidity, indicated by at least one temperature elevation. All of these cases were excluded from the category of major complications since the duration of febrile reaction apparently did not exceed 24 hours. The duration of febrile reaction was extremely difficult to determine because of the nature of the procedure used; nearly all charts showed that these patients received antibiotics at the first sign of temperature elevation.

In eight cases, uterine perforation was suspected and confirmed by the operator; these, of course, were placed in the major complication category. Five of these patients were treated by observation only, and no subsequent complications developed as a result of the perforation. Three patients were explored because of suspected intra-abdominal hemorrhage: Of these patients, two required hysterectomies to control blood loss, but the third patient required only evacuation of the remaining contents of the uterus and repair of the posterior uterine wall.

In the first trimester group, three patients required blood transfusions because of excessive hemorrhage. We have excluded one case from the

major complications category because of the non-specific nature of the case. The patient, in this case, underwent a suction curettage for removal of the fetal parts and placenta. She was subsequently seen in the emergency room, approximately one week later, where she expelled an additional fetus and placenta from an obvious twin gestation which had been missed at the time of the original procedure.

Table 3 outlines our complications with saline abortions. Of 127 patients, 27 developed major complications. Significant hemorrhage occurred in 11 patients, ten of whom required a curettage to complete the evacuation of a retained placenta or fetal parts. Two patients required transfusions. Major febrile morbidity occurred in 13 patients (10.2 percent of the saline cases). There were three cases of failed saline induction which required a second injection. After a second injection, one patient aborted spontaneously without any further complications. The second patient failed to abort and was given oxytocin; her posterior

lower uterine segment ruptured because of sacculation beneath the cervix with consequent expulsion of the contents of the uterus into the vagina. This patient was taken to the delivery room where inspection showed a 3 cm vertical laceration which required suturing by the attending physician. The patient experienced no further morbidity in her postpartum course. The third case of failed saline induction required re-injection; after the patient failed to respond to re-injection and became morbid with fever, she was taken to the operating room where a hysterotomy was performed.

Three patients required readmission to the hospital for treatment of postpartum bleeding, but these were not counted doubly since they are included in the postpartum hemorrhage section of the report. No case of disseminated intravascular coagulopathy occurred.

Table 4 outlines the complications of hysterotomy/tubal ligation abortions. Although some authors have excluded this procedure from the complications statistics, because of the double nature of the surgery, we felt that the procedure should be included since sterilization is only a minor portion of the surgery. We believed that sterilization per se should not add morbidity to the major portion of the procedure (abortion or hysterotomy).

According to our criteria, of 3 cases in this category, 18 patients developed major complications. Surgical hemorrhage, representing greater than 500 ml of blood loss, was present in four cases of which only one required a transfusion.

Table 3
Complications of Saline Abortion
North Carolina Baptist Hospital Study

January 1970 - October 1971

127 CASES*

	All Complications Number	Percent	Major Complications Number	Percent
Postpartum bleeding	11	8.7	11	8.7
Infection	23	18.1	13	10.2
Failed	3	2.4	3	2.4
TOTAL	37	29.2	27	21.3

* 67 private, 60 clinic.

Table 4
Complications of Hysterotomy—Tubal Ligation Abortion
North Carolina Baptist Hospital Study

January 1970 - October 1971

63 CASES*

	All Complications		Major Complications	
	Number	Percent	Number	Percent
Surgical hemorrhage	5	7.9	4	6.3
Infection	27	42.8	14	22.2
TOTAL	32	50.7	18	28.5

* 6 private, 57 clinic.

Again, infection was difficult to evaluate in terms of febrile morbidity and treatment. Most of the 27 patients listed under the category of all complications with possible infectious course were placed on a regimen of antibiotics shortly after the initial temperature spike. However, judged strictly from the criteria outlined, 14 patients were within the category of persistent temperature elevation above 100.4 F, despite antibiotic therapy; therefore, they were categorized as cases with major complications, representing 22.2 percent of the total.

We believe that the final figure—3 complications in 63 cases; a complication rate of 28.5 percent—probably represented less than the actual morbidity in this series. Although two patients were readmitted to the hospital and treated for one of the above complications, we did not count them twice.

Table 5 shows the procedures performed and the clinical status of patients who received a concomitant sterilization with their therapeutic abortions. Six private patients and

57 clinic patients were sterilized at the time hysterotomies were done. Nine private patients and 20 clinic patients had tubal ligations at the time of the first trimester abortion which was performed by dilatation and curettage, or suction. The total was 29 first trimester sterilizations. Two private patients and four clinic patients were sterilized by an abdominal tubal ligation after saline abortion. Ninety-eight patients were sterilized concomitant with therapeutic abortion in the total series of 536 cases, the sterilization rate being 18.3 percent. In the sterilization series, the patients showed no significant increase in morbidity.

DISCUSSION

We feel that the outcomes described in our data are primarily related to the type of procedure performed and to the gestation stage of the patient. In our first trimester terminations series, of the total 346 patients, an overwhelming majority of 240 cases (70 percent) were within the gestational age group of eight to ten weeks at the time of termination.

Sixty patients were thought to be between ten and 12 weeks' gestation, representing approximately 17 percent of the total group. Approximately two percent (eight patients) were found to be over 12 weeks' gestation at the time of the surgical intervention. The remaining 11 percent were at less than eight weeks' gestation at the time of termination.

It is probably unfair to judge our own complication rate by comparison to Tietze's¹ report on preliminary data. His original statistics appear to be an underestimation—1.8 percent major complications in patients within the New York area, with terminations between 11 and 12 weeks' gestation, including 3,212 patients—since in his study of complications in the first trimester gestational age group, the New York patients with follow-up reported a 10.9 percent complication rate, approximating our own percentage of 11.3 percent. A recent series, including 6,201 patients from California, reports that a complication rate of 2.7 percent occurred in termination between five and six weeks' gestation. Complications rose to nearly six percent for terminations between seven and ten weeks, and again sharply to 12.9 percent for terminations between 11 and 12 weeks.² Another study from Great Britain³ is difficult to analyze in terms comparable to those of our own and the California study, but it should be mentioned to reinforce our opinion regarding the high complication rate of abortion after the first trimester. In a series of 1,317 cases, over half of the patients were past the first trimester at the time of termination, and the total complication rate was 16.8 percent.

Stewart and Goldstein² reported a complication rate of 23.4 percent in combined morbidity statistics on terminations between 13 and 14 weeks' gestation and combined morbidity of 25 percent between 15 and 16 weeks' gestation. The use of intra-amniotic hypertonic saline for therapeutic abortion after 12 weeks' gestation has caused recent controversy and a wide variation of complication statistics, varying from 47.6 per-

Table 5
Therapeutic Pregnancy Termination
North Carolina Baptist Hospital Study

January 1970 - October 1971

STERILIZATION RECORD*

Procedure	Clinical Status		Total Number of Patients Sterilized	Number of Patients Undergoing Procedure
	Private	Clinic		
Hysterotomy	6	57	63	63
Anal/uterine evacuation	9	20	29	346
Ne injection	2	4	6	127
Total number of patients sterilized (procedures)	17	81	98	—

Sterilization rate, 18.3%.

cent⁴ to less than five percent,⁵ have been cited. A more recent study, from the Beth Israel Medical Center in New York,⁶ shows that 23 percent of their patients who received a saline injection required a second procedure to terminate the pregnancy.

Although large series on termination by hysterotomy are difficult to find in the literature, Stallworthy et al⁷ from Great Britain have sufficient data to compare with our own. Stallworthy reported on 1,182 patients, 70 of whose pregnancies were terminated by hysterotomy. In this study, ten patients experienced a blood loss of greater than 500 ml (14.5 percent), and an additional 30 patients had febrile reactions of greater than 100.4 F persisting for longer than 24 hours (43 percent). It is also interesting to note, from this same series, that of 290 patients undergoing vacuum aspiration and/or dilatation and curettage at less than ten weeks' gestation, ten percent experienced hemorrhage greater than 500 ml and 16.5 percent experienced febrile reaction greater than 100.4 F which persisted for longer than 24 hours. It is, at times, difficult to compare others' studies with one's own data, and it may be unfair to judge the quality of care without further knowledge regarding the experience of the surgeons, methodology, and sterile technique.

We feel that our experience and the experiences of our colleagues in eastern Europe, the Soviet Union, Japan, Scandinavia, Great Britain, and in the United States document the fact that the medical and/or surgical interruption of pregnancy is not

without risk.* Although complication rates were recently reported (15) in the New York area to be 3.8 per 1,000 for abortions performed in the first trimester of pregnancy, and 23.7 per 1,000 for those performed beyond the first trimester, 12 deaths were reported following legal termination of pregnancy from July 1, 1970, to December 31, 1971. During the same period, the legal abortion had some apparent positive effect upon maternal health in New York, in that the maternal mortality rate has declined 37 percent from 1970 to 1971, reaching an all time low of 2.9 deaths per 10,000 live births. In the state of California,² since the inception of the therapeutic abortion law of 1967, there have been five reported deaths attributed directly to abortion legally performed, with an incidence rate of five per 90,000, or approximately five to six per 100,000 abortions. According to these statistics, three of the California deaths occurred either during uterine evacuation, or shortly after termination of pregnancy by uterine evacuation by means of a curettage; the other two deaths occurred in patients undergoing saline mid-trimester abortion. We are fortunate to be able to report that there were no fatalities in our series.

Because of our lack of experience with long term latent effects of therapeutic abortion, in this paper we have considered only the immediate medical and surgical complications of therapeutic termination of pregnancy. A positive correlation between previous abortion and placenta previa, abruptio placentae, cervical incompetence, prolonged labor, and endometriosis has been re-

ported in Czechoslovakia.¹⁰

The patient's decision to terminate pregnancy, by any means, apparently only rarely involves a consideration of serious risks to her life. We believe, however, as a result of the data which we have presented and that of other authors, that therapeutic abortion beyond ten to 14 weeks' gestational age is not without a major increase in serious complications. It is, therefore, our recommendation that, if at all possible, the procedure should be performed before the tenth week of gestation, and certainly no later than the twelfth week. If therapeutic abortion is to be considered after the twelfth week of gestation, the increased risk of major complications of mid-trimester termination should also be considered.

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Nor are examples wanting, either in ancient or modern times, of the baneful consequences which have arisen from an injudicious application of the warm bath; but as warm baths are not so common in this country, and are seldom used but under the direction of a physician, I shall not enlarge on that part of the subject.—William Buchan: *Domestic Medicine, or a Treatise on the Prevention and Cure of Diseases by Regimen and Simple Medicines, etc.*, Richard Fowell, 1799, p. 427.

The Tail Is Wagging the Dog

Bernard A. Wansker, M.D.*

THE purpose of this article is to discuss the North Carolina Medical Society's concern with health care costs and to tell about the activities of the Society regarding physicians' fees and insurance. We wish to consider particularly the question of "reasonable and customary charges" and "peer review." Some of the material herein has been adapted from a testimony which was presented to the Joint Subcommittee on Health Care Costs of the North Carolina General Assembly on October 17, 1973; other portions are adapted from various writings of the author. Since this article does encompass a substantial amount of material reflecting the author's personal views, it should not, except as indicated, be considered official policy of either the Insurance Industry Committee or of the North Carolina Medical Society. On the other hand, it probably reflects little with which either would disagree. The North Carolina Medical Society enjoys excellent rapport with health insurance carriers in this state. We often disagree, but we do so as gentlemen, and we communicate freely and frankly. The Insurance Industry Committee operates a

retrospective peer review service, the Claims Review Service. A spokesman for the insurance carriers has characterized the service we perform as follows: "We are fortunate in North Carolina in having one of the best peer review arrangements in the United States—the North Carolina Claims Review Service." In turn, the cooperation, communication, and liaison which the Medical Society has enjoyed with the insurance carriers has made such an arrangement possible and productive. Further refinements which are anticipated by the activation of the North Carolina Medical Peer Review Foundation should markedly increase the quality of the decisions that are reached.

THE CLAIMS REVIEW SERVICE

The function of this service is to advise the commercial insurance carriers and the Part B Medicare carriers of their responsibilities to their insureds under the terms of the insurance contract or of the Medicare program (Part B Medicare deals with physicians' fees—not hospital bills).

Specifically, the Claims Review Service is asked to give an opinion regarding the carrier's responsibility for reimbursement of professional charges and/or for an opinion as to

the necessity of the services rendered.

Confusion apparently exists in regard to the concept of a "reasonable" charge as it applies to insurance contracts and as it applies to a private relationship between a physician and his patient. They are not necessarily the same.

Reasonableness, as beauty, is in the eye of the beholder. How does one define it? How does one determine it? To place a dollar value on a medical service is no easier than answering the question, "How long is a piece of string?" A fee which seems quite reasonable to a physician (and probably to his patient) may not be considered reasonable to (a) Medicare (b) Medicaid (c) CHAMPUS (d) Workmen's Compensation (e) Veteran's Administration (f) Vocational Rehabilitation, or (g) private carriers. At the same time, one or more of these agencies might consider the fee reasonable, whereas one or more might consider it unreasonable.

DEFINITIONS

The "prevailing charge" as defined by the American Medical Association and by the United States Government is as follows:

American Medical Association

Usual charge: that made at least 50 percent of the time by a specific

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doctor for a specific service.

Customary charge: that charge made by most physicians of similar training and experience in the same geographic area.

Reasonable charge: a charge meeting the definition of both Usual and Customary.

U.S. Government (Medicare)

Customary charge: that made at least 50 percent of the time by a specific doctor for a specific service.

Prevailing charge: that charge which will cover 75 percent of the charges (not 75 per cent of a charge) made by physicians of similar training and experience but not necessarily in a geographic area.

Reasonable charge: a charge meeting the definition of both Customary and Prevailing.

Thus, whereas specific differences exist (and they are of the utmost importance), usual = customary, and customary = prevailing. I think it is much simpler to ignore the question of "usual" since we are talking about the physician's "regular" charge, for both the AMA and the Government.

Let us enlarge upon our new friend PREVAILING. Let us consider the fee charged for a specific service by a physician. How does Medicare, for example, find out what is prevailing? Here's how: Let us say that for a given period of time, from a specific area, and from surgeons alone, Medicare accumulates actual charges submitted for the specific service. Now let us assume that they have accumulated 100 actual charges which they arrange from lowest to highest. Medicare counts the first 75 actual charges and calls this the 75th percentile (not percent). This 75th percentile covers 75 percent of the charges submitted (not 75 percent of a charge). As an example, the charge screen might look this way:

Actual charges submitted:	\$50.00
Number of charges submitted:	10

Actual charges submitted	—
Number of charges submitted:	—

In this example, 75 percent of the charges submitted are \$75.00 or

less. Hence, any charge of \$75.00 or less will be considered by Medicare to be prevailing, and therefore, reasonable. It is entirely possible that a higher percentile could still have \$75.00 as its highest figure. As a matter of fact, if all the submitted charges had been \$75.00, even the 100th percentile would have had \$75.00 as the highest figure.

Who, then, establishes the range of fees submitted? Who, then, establishes the individual physician's profile; i.e., the fees he charges for various services? Not the insurance companies; not Government agencies. The physician does.

In my opinion, this prevailing charge concept is the single most important change in insurance carrier (private or Government) reimbursement to date, and it portends significant influences upon private fee-for-service medicine. I want to emphasize that Medicare no longer uses relative values in determining its payments. Certainly, with its enormous data bank, no longer a secret, i.e., since a court test has been won against the Government (and the Government failed to appeal), the public is now entitled to physician profiles (not of individual physicians, but of specialties). I doubt that John Q. Public would be able to make much out of a few hundred pounds of computerized data, but you may rest assured that every insurance company in America that is large enough to rent a computer will soon have this data and will no longer use relative values.

Hopefully private insurance companies will use a more satisfactory (to physicians) percentile. Initially, Medicare started at the 83rd percentile; private carriers have been known to be in the low 90s; but an additional factor must also be appreciated—Medicare is required to establish certain areas which often are not geographic. For example, in a given state, the larger cities may be

\$55.00	\$60.00	\$65.00	\$70.00	\$75.00
5	10	10	10	30

\$80.00	\$85.00	\$90.00	\$95.00	\$100.00
5	0	15	0	5

grouped together; then the medium sized cities; then the smaller com-

munities. And, a medical school itself might be designated as an area. Other states might conceivably be divided geographically as east, central, and west.

Private insurance companies are under no such compunction; they may elect any area, geographic or not, and any percentile they choose. How, then, can anyone tell what is prevailing?

Relative value studies

Rarely does one find that relative value studies are accurately referred to. Most of the time they are referred to as relative value schedules. There is a great difference; it is not a matter of semantics. A study is a study, a guide, a teaching document. A schedule is a schedule, a list, a useless "cookbook" designed for a clerk to utilize. Already, insurance carriers are ignoring the individual specialty relative value studies in those instances in which relative values are still being used) whenever and wherever such individual F/S unit values are higher than the same service coded under the California 1969 RVS. To think that insurance payments are going to be increased merely because a unit value is changed is a misplaced hope. Even if the price commission would allow it, the insurance carriers are going to pay according to their prevailing data. Their major medical contracts call for the payment of reasonable and customary charges and they do not call for specific unit values which are multiplied by conversion factors.

It seems that having prevailing levels of charges for services, as defined by the Current Procedural Terminology (CPT-73) and obtained under ground rules acceptable to all parties concerned, is the only way to preserve, as far as possible, the fee-for-service concept and it seems that it is the only way to avoid a fee schedule which is not reflective of individual differences and regional variations. A relative value study, when erroneously used as a schedule, requires the use of a fixed conversion factor in each of the various conditions; it does not permit, nor accom-

update, the flexibility reflected in an individual's profile. A profile which is varied in this fashion accurately reflects the personal modifications at the physician has elected to make, consciously or not, in a relative value study. Again, each individual physician has already established his own charge pattern (profile). No one else did it for him. Massive confusion and inequities in, will, and must be avoided by the use of the concept "prevailing" rather than relative value "schedules" which are developed by each specialty and subspecialty organization that wishes to do so (and which differs from the California 1969-1973 relative value studies). The California studies do not separate, whatsoever, the various specialties and sub-specialties. Therefore, significant differences in unit values result, depending upon which schedule one wishes to utilize. Hence, there is, as previously indicated, a conflict already existing within the relative value family; the California study is still the standard. In my opinion, the sooner relative value studies are relegated to the status of relics, especially for physicians who are new in practice, the better it will be for all concerned. Let us waste no more time on them—they are on their way out.

CARRIER RESPONSIBILITY FOR PAYMENT

the science of medicine

The problem of benefit determination in major medical insurance has since the insurance contract usually restricts liability to reasonable and customary charges. When a fee exceeds the carrier's prevailing charge, the matter is brought to the Claims Review Service. What do we consider and what do we have available to consider? We can, and we do, obtain the hospital record consisting of the patient's history, physical examination, order sheets, progress notes, pertinent laboratory data, operative notes, and discharge summary. We also consider any additional information submitted by the carrier or by the physician; the nature of the medical or surgical problem presented

and what the physician did about it; the uniqueness (if present) of the situation, and we give due allowance for that; and the submitted charge as compared to the prevailing range of charges determined by the carrier. Finally, after we take a vote, we give the carrier a figure which we feel represents a fair judgment as to the carrier's responsibility to its insured; that is, its responsibility for defraying the costs of the science of medicine for its insured. We do not give an opinion as to the value of the art of medicine furnished, and we do not consider such a determination to be the responsibility of any carrier.

The art of medicine

In the consideration of "reasonable" as it applies to the private relationship between a physician and his patient, many factors in addition to the science of medicine must be considered. These usually do not appear as part of the medical records. One must consider the individuality of the physician and his practice; the type and scope of services he renders; the facilities he has provided and his availability to utilize them; the time and energy he spent before, during, and after the services were rendered; the special considerations demanded by the patient and/or his family; the agony or delight in handling the patient; the study, contemplation, consultation, and teaching involved; the physician's cost in time, facilities, and expense in rendering the service; and the relationship developed with the patient and/or the family, as it plainly reflects the art of medicine. There are no standard patients. There are no standard physicians. And, the longer one practices medicine, one sees fewer and fewer standard diseases.

Do any two physicians actually render an identical service? It is nearly impossible, in most instances, to determine whether or not a private fee is, or is not, reasonable in the context of a private contract. As far as the patient is concerned, a far different view of "reasonable" exists. Did the service afford relief to the patient? If not, in his opinion, it

wasn't worth much; on the other hand, if the service brought relief, it's nearly priceless. Physicians whose fees are substantially higher than that which prevails in their community, and whose fees are unaccompanied by the art of medicine, soon find that this situation will create a backlash of turbulence which is quite difficult to tolerate. Such a physician would soon have no practice.

The Claims Review Service finds it regularly compatible to give a carrier a determination of what is, in the opinion of the Claims Review Service, a reasonable fee in the context of the carrier's allowable expense or liability under the terms of the insurance contract with its insured; at the same time, it recognizes that prevailing fees are not to be equated with reasonable fees. It is entirely possible for a physician to charge a fee which we think is greater than the carrier's liability; and yet it can, and does, fall into a range in which it would not merit further study or review. Was the fee agreed upon in advance? If so, it was reasonable and no more can be said; the matter would be closed. It would be a solidly agreed-to contract. Fees are regularly discussed in advance, and often the conversation is initiated by the patient or by the family.

THE PHYSICIAN/PATIENT RELATIONSHIP

It has been stated that "there is an unwillingness, based on ethical grounds, for any medical society to directly intervene in the patient/physician relationship, including the freedom of a physician to set his own fees"; and that "peer review cannot be complete and of direct benefit to the public unless the medical profession is willing to protect the patient against excessive charges." On behalf of the North Carolina Medical Society, the record must be corrected and our position must be re-emphasized: A charge is not necessarily excessive simply because it is not prevailing. And, the small fraction of claims, reflecting charges that are higher than prevailing, belays the question of protecting

the patient against excessive charges. Insurance carriers regularly equate "prevailing" with "reasonable"; that "prevailing" and "reasonable" are synonymous is not necessarily accurate.

Further, private insurance companies are now using data which they accumulated to determine prevailing levels of charges. We, as physicians, have no information as to the amount of data used, the timeliness of the data, the areas considered, the breakdown or lack of breakdown by specialty, or the percentile. I can think of no more pressing a need than to have an organization which is not the arm of medicine, not the arm of insurance, and not the arm of Government, to accumulate data in order to determine prevailing levels of charges. First, we all would have to agree on the following: What areas are to be used? What specialties? What time limit? What percentile? Then, who is to do the work of compiling the data? Who is to pay for it? My suggestion is that the non-profit North Carolina Medical Peer Review Foundation, Inc. have the responsibility as part of its accumulation of PSRO data. Private carriers could well do the funding.

Nonetheless, we do intervene to protect the patient from "excessive" charges. Every county medical society in this state has a Grievance or Mediation Committee. And, properly, it is "at home" that such problems are best handled, whether arising via an insurance claim or via a direct complaint from a bill submitted to a patient. If the matter cannot be resolved at this level, the problem is referred to the Committee on Mediation of the North Carolina Medical Society. This Committee is composed of the last five past-presidents of our State Society. It has very strong investigative and persuasive powers. In isolated instances, its findings are referred to the Board of Medical Examiners of

the State of North Carolina.

Again, carefully place in your mind that these are very unusual circumstances. The largest private health insurance carrier in the nation reported that, nationally, it was experiencing only five percent of all charges above its prevailing levels. In North Carolina the percentage is thought to be considerably less. The Claims Review Service reviews fewer than 100 cases[†] annually, and many of them are not for fee adjudication, but are submitted for reasons such as utilization or liability for a service or facility. And what happens to the cases that are submitted for fee adjudication? Some are sustained as being acceptable; others are moderately reduced; and the rest are reduced substantially. By and large, our review system is an acknowledged success. The whole commotion of protecting the public from excessive charges by physicians is certainly not reflective of the facts of the matter.

FEE CONTROLS

It might seem that it has been suggested that physicians should be held to prevailing levels of charges in those instances in which major medical contracts call for reimbursement on that basis. If this were done, there would exist a maximum fee schedule which would become a minimum as soon as the knowledge became disseminated. Do not forget that many charges are less than the specific percentile which a particular carrier may choose as its cut-off point. Carriers do not voluntarily elevate the submitted charge to the cut-off percentile if it falls below it.

It may well be, in the future, that physician reimbursement will be handled on a capitation basis; or on a fixed fee schedule such as mandatory indemnity schedules would provide; or limited by the prevailing level of charges. The philosophy of these concepts is being widely debated, as are Government controls on all segments of society in general. Nonetheless, a decline in initiative, a reduction in quality, and a stagnation of the medical mind can be expected if any of these measures is

adopted. As long as all purveyors of personal services are protected by the 13th Amendment to our Constitution,[‡] no one will have the right to tell anyone that he must perform a personal service for another, at a price determined by a third party and not mutually agreed upon. A physician does have the right to charge that amount which he believes his services to be worth, as does anyone else. This is the for-service concept which is inherent in a free enterprise system. The North Carolina Medical Society does not set fees. Even if it wished to do so, the antitrust statutes would prohibit such action. Yet this does not mean that the North Carolina Medical Society advocates reckless abandon in setting fees. Quite the contrary, members are urged to very carefully consider their charges in order that the fees be commensurate with the services rendered.

The North Carolina Medical Society agrees that organized medicine would be ill advised to defend the right of any physician to make charges which are considered by organized medicine to be unreasonable, since it would be a reflection upon the entire profession. But again, the problem of charges which are obviously unreasonable or excessive, by anyone's definition, is extraordinarily rare.

Federal policy

One cannot fail to observe that the physician's prerogative to collect the difference between the prevailing charge and his own usual fee has often been attacked by the Federal Government. The right to accept or not to accept assignment under Medicare has been kept inviolate. When a physician does not accept assignment of the Medicare payment, he has every right under the law to collect the full charge from the patient. If he does accept assignment, he must accept the Medicare (prevailing charge) determination as his full charge. It would seem inappropriate for other agencies or carriers to advance the suggestion of mandatory prevailing fees with the Federal Government, with its

[‡] The Blue Shield Committee handled 275 to 300 cases in the past fiscal year.

[†] Neither slavery nor involuntary servitude, except as a punishment for a crime whereof the party shall have been duly convicted, shall exist within the United States, or any place subject to their jurisdiction.

uge data bank, has not seen fit to lo so. I firmly believe that Part B Medicare in North Carolina would agree that physicians do not present much of a problem in the area of fees, and even less in the area of overutilization.

WHAT CAN THE CARRIERS DO?

A viable private health insurance industry is an obvious necessity if a private system of health care delivery is to be maintained. However, a controlled system of fee reimbursement would not be palatable to organized medicine generally; and this arrangement would be unsuitable specifically in the event that all private insurance carriers became merely fiscal agents of the Government. Demands upon the nation's private health carriers to insure anything and everything in full—a practice which does extreme violence to the concept of insurance itself — can be achieved only at an

\$ In 1972, physicians' fees rose 2.4 percent, according to Government figures.

incalculable cost. Yet, the carriers yield to this demand and they expect physicians to keep "impossible" costs "in line." There is no question that health insurance premiums are regarded as part of health care costs. No one is more aware of that than practicing physicians. Time after time we hear complaints about high premiums and poor benefits. One of the ways the private carriers can help is by examining the ratio of premium income to insurance carrier expenditures for accident and health insurance policies. The percent that is returned in benefits to policyholders possibly should be held to a prevailing range. In any event, insurance carriers are not in business for entirely altruistic reasons.

CONCLUSIONS

The problem of reasonable health care costs is of vital concern to the North Carolina Medical Society. We pledge our best efforts in achieving the delivery of health care to the public we serve at the least possible cost, commensurate with quality. *Reasonable costs are not necessarily*

equivalent to prevailing costs; costs in excess of prevailing are not necessarily excessive. Physicians are still under Phase II-III of the Cost of Living Council. Therefore, their fees cannot rise more than 2.5 percent per year, and then only if costs are not offset by productivity. Hence, by law, physicians must hold the line on fees while at the same time they must absorb costs of an inflationary tide which is estimated to be climbing at a rate of three and one-half times the 2.5 percent ceiling. It seems that organized medicine is getting a bad "rap" from those who have been unable to distinguish the difference between rising institutional costs and rising professional charges. It's the apples and oranges problem.

Physicians' fees should be fair; they should not be wagged by a tail called "prevailing," "usual," "customary," "reasonable," "relative value," or what have you. The North Carolina Medical Society sincerely believes that the physicians of this state and of this nation are holding the line on health care costs. We urge others to do the same.

The cold bath recommends itself in a variety of cases, and is peculiarly beneficial to the inhabitants of populous cities, who indulge in idleness, and lead sedentary lives. In persons of this description, the action of the solids is always too weak, which induces a languid circulation, a crude indigested mass of humours, and obstructions in the capillary vessels and glandular system. Cold water, from its gravity as well as its tonic power, is well calculated either to obviate or remove these symptoms. It accelerates the motion of the blood, promotes the different secretions, and gives permanent vigour to the solids. But all these important purposes will be more efficiently answered by the application of salt water. This ought to be preferred on account of its superior gravity, and for its greater power of stimulating the skin, which promotes the perspiration, and prevents the patient from catching cold.—*William Buchan: Domestic Medicine, or a Treatise on the Prevention and Cure of Diseases by Regimen and Simple Medicines, etc., Richard Folwell, 1799, p. 427.*

A Community of Care

Peter James Lee*

WHAT is to follow came originally as an interlude in a two-day symposium on malignant disease, and the papers which emerged from those sessions have already appeared in the JOURNAL. The two days were highly technical examinations of difficult and complex subjects. The interlude was a symbol in which the context of the issues was resolved, a symbol of the relationship between what you do in your work and how your work relates to the community. As a layman in a gathering of specialists, I represented the larger context—a shifting one—in which medical care is administered.

I represent some other things. I am a priest — a holdover from an age when the priest was the community's dominant symbol of care and the surgeon was the barber with a knife. Priesthood, in many ways, is a bad word. For many people it means an elite caste, a fraternity of mystery, and too frequently, a brotherhood that stands for care but which often represents authority directed toward self-preservation. In this secular age, for better or for worse, the priesthood of which I am

a part has been driven (or has fled) to the sidelines. Although physicians are not called priests, I suggest that for the great masses of the population you represent many of the attributes of priesthood — an elite caste; a fraternity of mystery; and, sadly, because a minority can create an unfair image, the medical community sometimes represents a moral authority directed toward self-preservation. Speaking for a priesthood that has lost much, yet weathered the storm, welcome aboard! But that's history for me and prophesy for you.

I invite you to explore the wider context in which care is exercised. As a priest I am a symbol, however inadequate, of a tradition of care. You, the medical community, are the people who now maintain that tradition.

"Care" is a word I use to suggest the range of actions by which society copes with persons who are sick: it may be the obscure probings of a research physician who never sees a patient; or it may be the direct relationship of a physician, nurse, or chaplain, to the patient and his family. Care may be the political activity of citizens who are concerned with increasing public responsibility for medical research and delivery of medical treatment to all citizens, regardless of their economic condition.

Not too many years ago, and even

now in some places, the term "helping professions" was used to describe physicians, clergymen, social workers, and others who could fit under that umbrella. I suggest that that term is obsolete. The sophistication of our social system requires the use of an incredible variety of professions to make any system work. Lawyers, accountants, air conditioning engineers, and even vending machine operators are essential in the contemporary medical center if the complicated, multi-faceted system is to work effectively and relatively free of frustration. Care is a word which we can no longer use to describe actions by those unusual, gifted, committed, and skilled people who relate to suffering individuals on a one-to-one basis.

The exercise of care is no longer the exclusive province of the priest, the physician, the hospital, or the helping professions. In a period of transition, care has become broader than the professions; so broad that in this time of transition, the concept of care may lose its significance. If society assigns to no one the specific tasks of caring, then in a human context of assistance to the sick, does care give way to a technical, pathological process by which diseases are treated and persons ignored?

In my experiences with a range

Adapted from an address delivered at the Sixth Annual Symposium on Malignant Disease, University of North Carolina School of Medicine, Chapel Hill, North Carolina, April 6, 1972.

* Rector of the Chapel of the Cross, Chapel Hill, North Carolina 27514

of people both inside and outside of hospitals, I have seen the hopeful young couple with a healthy child; the elderly, terminally ill husband whose wife never leaves his bedside; the family member who, in the midst of life, is told of his fatal malignancy. Through all of my experiences, I have realized that care — that sustaining, affirming expression of competent action and genuine concern — takes place through a variety of channels and in many ways. There is no specialist of care in this transitional age, no one person who, in fact or in symbol, provides the primary sustaining support.

What we need, I think, is a community of care that recognizes a style of relating to the sick which transcends, but includes, the traditional personal style of the helper to the person in need of help.

The concept of a community of care removes the luxury in the assignment of care to the specialists, and it requires a rediscovery of the common bond of human concern and feeling among all people who touch the lives of the sick. This concept, that the entire context of therapy, research, and support for the sick must bear the responsibility of thoughtful and sensitive care, also honors the technical specialists' work as an essential component in the community of care. Too often the essential work of the unseen researcher, administrator, technician, and others is considered to be a supporting service only. It is also too often thought that those persons who are responsible for direct patient care have a greater responsibility for sensitivity to patients as human beings. I am suggesting that the entire structure of the development and delivery of medical services needs to discover its identity as a community of care.

The image of the "family doctor" still kindles hope among the sick. The ideal of the medical profession held up this symbol as the ideal of care. The development of renewed interest in family medicine demonstrates its power. However, in the complexity of contemporary medicine, the family doctor, as the help-

ing professions, is a fundamentally obsolete symbol. We have lost the "family doctor," and the "helping professions" is more a slogan than a reality. With that loss, attention to the sick has become a bureaucracy of technique in the absence of a community of care. Nevertheless, the deeper power expressed in these concepts is still an essential ingredient for humane and considerate attention to the sick. That power is a message to the patient that he is respected in his human dignity and honored as an individual with particular physical, emotional, and spiritual needs.

I have been astonished by the dignity and maturity of terminally ill patients, especially that of children in the face of death. Being with such a person in his last hours, as he slips toward that darkness which eventually we all encounter, is an experience that should summon the best resources of humility and respect at our command. Too often we do not summon such resources, but instead take flight from our humanity into the frenzied attention to technique. No one is at fault. Our symbols are inadequate.

Recovery of appropriate symbols cannot mean a return to the idealistic notion of one-to-one therapy between a family doctor and a patient whom the doctor has known since infancy. We need to develop new symbols for future medical care so that the power of humane concern is enhanced in the most sophisticated and complex systems.

I propose that attention to the state of our community could be a first step toward the development of appropriate symbols. We need to transform mindless bureaucracies into sensitive communities — commonwealths in which all the people making up the medical community share a common concern. Whatever the diversity of their own technical skills, all people in the medical community should realize that they share, by the virtue of their humanity, common strengths in sustaining life, in nourishing hope, and in honoring the dignity of all persons.

The transformation of bureaucratic medical techniques into communities of care introduces a note of imprecision into disciplines that must be rigorous in their precision. But human life, by definition, is indefinite and imprecise and not easily categorized. The exceptions to the necessary disciplines teach us less about the inadequacy of our rules than about the diversity of people.

A community of care honors that diversity among patients as individuals who need different sorts of support and attention, and who require different disciplines. The terminally ill, for example, are rich in their diversity. Some are already spiritually dead. Others, in their dying, discover resources of life they never knew before. All people deserve the dignity of a community of care in which to die, rather than the insensitivity of a bureaucracy that holds their dying bodies in custody while their ignored spirits radiate life.

How to provide a community of care is another question, but perhaps the task is surprisingly simple, for the development of a community of care needs first the nourishment of our gifts as persons, then our talents as professionals.

The development of such a community obviously requires attention to the personal dimension of patients' needs. But it also requires society's respect for those persons who work together in the medical community — respect for their humanity, as well as respect for their skills. Finally, the development of a community of care requires broad attention to the political and economic structures of a society that can easily crush the individual human spirit unless persons are regarded as individuals and not simply as statistics. We need a recognition of the diversity among people, an honoring of the depths of human life, and an acceptance of life's limits and mystery.

My presentation and the contribution of the specialists at the symposium on malignant diseases were directed to the simplicity and to the

profundity of every single human life—to honor that life, to release its energies, to respect its ending when the time comes, and to respect our common bonds with that life. These are the central tasks of any community of care. The individual human life is the beginning and the end of our work, regardless of our religious and philosophical traditions.

James Agee, that perceptive Southern writer who understood the

caring of one person for another, described the dignity of human life that provides the impetus for care:

All that each person is, and experiences, and shall never experience, in body and mind, all these things are differing expressions of himself and of one root, and are identical: and not one of these things nor one of these persons is ever quite to be duplicated, nor replaced, nor has it ever quite had precedent: but each is a new and incommunicably tender life, wounded in every breath and almost as hardly killed as easily wounded: sustain-

ing, for a while, without defense, the enormous assaults of the universe.¹

A community of care recognizes the strengths of the world's assaults, but the community of persons who care is ultimately victorious in its affirmation that life — the individual human life — is what matters; and finally, it is all that matters.

References

1. Agee J, Evans W: *Let us Now Praise Famous Men*, Boston: Houghton Mifflin, 1941 (reprinted, 1960).

In what is called a plethoric state, or too great a fulness of the body, it is likewise dangerous to use the cold bath, without due preparation. In this case, there is great danger of bursting a blood-vessel, or occasioning an inflammation of the brain, or some of the viscera. This precaution is the more necessary to citizens, as most of them live full, and are of a gross habit. Yet, what is very remarkable, these people resort in crowds every season to the seaside, and plunge in the water without the least consideration. No doubt they often escape with impunity; but does this give a sanction to the practice? Persons of this description ought by no means to bathe, unless the body has been previously prepared by suitable evacuation.—*William Buchan: Domestic Medicine, or a Treatise on the Prevention and Cure of Diseases by Regimen and Simple Medicines, etc.*, Richard Folwell, 1799, p. 428.

Editorials

HOW TO KNOW WHAT IS GOING ON

With continuing education becoming a requirement for membership in the North Carolina Medical Society, it is important to make sure that many and varied continuing education opportunities exist for our members, and that physicians know when and where these opportunities are available. County medical societies, specialty groups, medical schools, volunteer health associations and others join to offer a continuous string of courses, lectures, seminars and symposia. Each month the NORTH CAROLINA MEDICAL JOURNAL tells you about many of these which will take place in North Carolina and our adjoining states.

"WHAT? WHEN? WHERE? In Continuing Education," which was mentioned in the "President's Newsletter" for October, appears each month in the "Bulletin Board" section of the JOURNAL. Continuing Education opportunities which will take place during the next five and one-half months are listed, usually with topic, place, sponsor(s), and where to write for additional information. Credit available, registration, fees and other items of special interest are given when these are known and considered pertinent.

The column is organized in two sections, "In North Carolina" and "In Contiguous States." The latter, of course, includes Georgia, Tennessee, South Carolina and Virginia. In many instances a doctor in North Carolina is closer to a good meeting in a bordering state than to one in his own state.

The listing period covers from the 15th of the month, the date when the JOURNAL usually is mailed, through the following five months. An item is carried during this entire five and one-half month span if it is received in time. Items for listing must be received by the 10th of the month prior to the month in which they will appear.

WHAT? WHEN? WHERE? is available to help publicize any activity which has educational potential for physicians in North Carolina, and/or for those who work directly with these physicians, if the meeting is within the geographic area specified above, and if it is "open," rather than restricted to an "in house" group, such as a board of trustees, school faculty, committee, or the medical staff of one hospital.

The JOURNAL welcomes any opportunity to increase the listing of learning opportunities which are available to its readers, and of which they otherwise might not be aware.

To request listing for a learning activity, or if you would like a copy of "Information for Contributors" and a form on which to submit information for an activity you would like listed, write to WHAT? WHEN? WHERE?, P. O. Box 8248, Durham, North Carolina 27704.

To find out where the action is in continuing medical education read "WHAT? WHEN? WHERE?" each month, in the NORTH CAROLINA MEDICAL JOURNAL.

RON W. DAVIS, Ed.D.

Emergency Medical Services



CATEGORIZATION OF HOSPITAL EMERGENCY DEPARTMENTS HOW IT WAS DONE IN OHIO

**Maurice A. Schnitker, M.D.
Clinical Professor of Medicine
Medical College of Ohio at Toledo**

Forty-two hospitals in northwestern Ohio were studied and categorized by a team of physicians. The four categories of the National Research Council and the National Academy of Science were used: Type I, Major Emergency Facility; Type II, Basic Emergency Facility; Type III, Standby Emergency Facility; Type IV, Referral Emergency Facility.

At the time of the initial study, there were no Type I installations in northwestern Ohio. Because of the study, within a year, 13 of the surveyed hospitals had improved their status. The team chose to

categorize a hospital rather than having the hospital categorize itself. They thought this was a wise move. To help in the upgrading of the hospitals, training programs for nurses in the intensive care unit, coronary care unit, and courses to train technicians for operating rooms, laboratories and ambulance services were set up at the Medical College of Ohio. The city of Toledo adopted training requirements for ambulance technicians and set up a monitoring service.

The author thought this program was a step forward in improving emergency medicine.

Abstracted by GEORGE JOHNSON, JR., M.D.

From "Emergency Medicine Today." The original article may be obtained from the American Medical Association, 535 North Dearborn Street, Chicago, Illinois 60610.

Committees and Organizations

COMMITTEE ON PEER REVIEW

September 28, 1973

The following motions were approved, in effect:

That the committee serve as a coordinating body to meet at frequent intervals with the review committees involved with claims review to coordinate the problems. The committee would make certain educational efforts as are deemed necessary in the particular cases. If they cannot correct the problem, they would refer it as a profile to the Mediation Committee for whatever action they deem necessary.

That the committee recommend to the Executive Council that a study in conjunction with the licensing board be undertaken to establish authority for the Executive Council of the Society to take punitive action in those cases deemed necessary by the Mediation Committee.—M. FRANK SOHMER, JR., M.D., *Chairman.*

COMMITTEE ON CHRONIC ILLNESS, TB AND HEART DISEASE

September 26, 1973

Whereas in 1972 reports were made to public health authorities of 996 new active cases of tuberculosis with 60 percent being over the age of 45 and 70 percent being male, 130 reactivations of tuberculosis and 113 deaths attributed to tuberculosis in North Carolina,

And *Whereas* in 1972 North Carolina had the twelfth highest new active tuberculosis case rate in the nation (19.1 per 100,000 population compared to US rate of 15.8 per 100,000), the committee recommended to the Executive Council that the following be done:

1. A renewed effort to identify and bring to treatment cases and potential cases of tuberculosis among the population;

2. That where treatment is indicated every attempt be made to select, with appropriate consultation and laboratory investigation as necessary, an adequate regimen of anti-tuberculosis drug therapy for a minimum of two years of uninterrupted treatment in the case of active or probably active disease;

3. That the initial phase of treatment of active cases covering the period of possible infectiousness should in most cases take place in a hospital having the necessary medical, laboratory and supporting facilities for full evaluation and formulation of optimum drug therapy plans, and

4. That responsibility for supervising the carrying out of treatment at home and epidemiological investigation of cases including the reporting of new cases be actively shared with public health authorities.

The tuberculin skin test was recommended as the initial screening procedure of choice in tuberculosis case finding.

The committee also decided to re-submit to the Executive Council their recommendation on the preventive use of Isoniazid, in effect:

The committee endorses the preventive use of Isoniazid in those situations where, in the opinion of the individual's physician, or one or more physicians, experienced in tuberculosis, such would be in the best interest of the health of the individual, his family or community from the point of view of preventing further spread of infection. Those included may fall into one of the following groups:

1. Infants and young children with a history of household exposure to an infectious case of tuberculosis;

2. Recent close household older child and adult contact of an infectious case of tuberculosis who have significant tuberculin hypersensitivity;

3. Previously untreated children 20 years of age and under who have significant tuberculin hypersensitivity;

4. Known recent tuberculin converters of any age who have significant tuberculin hypersensitivity;

5. Certain medical situations involving uncontrolled diabetes mellitus, silicosis and those with peptic ulcer about to undergo gastrectomy where the patient has significant tuberculin hypersensitivity and for those who are placed on corticosteroid therapy;

6. Certain previously untreated or inadequately treated, inactive or quiescent cases of tuberculosis;

7. The committee recommends in each situation that the risk of known side effects of Isoniazid be evaluated against the possible advantage to the individual and community before deciding to institute therapy, and that when Isoniazid is prescribed, periodic (monthly) inquiries be made of patients receiving it in order to detect occurrence of any adverse side effects as early as possible.

The committee reviewed and approved the "Referral and Treatment" form (DHS-1500) of the Department of Human Resources, Division of Health Services, as was presented, and recommended the following to the Executive Council:

That the Society continue to endorse home health services and recommend the development and extension of home care to areas not having these services at the present time.

The committee also discussed the desirability of having a medical director for long-term facilities, as well as the guidelines of what the director should do with the following recommendations to the Executive Council:

That the Society endorse the principle that long term care facilities in North Carolina employ the services of a physician to serve as medical director.

That the Society endorse the "Guidelines for a Medical Director in a Long Term Care Facility" as adopted by the AMA and that copies of these "Guidelines" be forwarded to the N. C. Department of Human Resources and to the N. C. Health Facilities Association with the recommendation that these respective agencies and organizations take similar action of endorsement.—DIRK VERHOEFF, M.D., *Chairman*

Another class of patients, who stand peculiarly in need of the bracing qualities of cold water, is the nervous. This includes a great number of the male, and almost all the female inhabitants of great cities.—*William Buchan: Domestic Medicine, or a Treatise on the Prevention and Cure of Diseases by Regimen and Simple Medicines, etc. Richard Folwell, 1799, p. 428.*

Bulletin Board

WHAT? WHEN? WHERE?

In Continuing Education

February 1974

("Place" and "sponsor" are listed only where these differ from the place and group or institution listed under "for information.")

In North Carolina

February 15-16

31st Annual Watts Medical and Surgical Symposium
Place: Durham Hotel & Motel, Durham
Sponsor: Watts Hospital Medical Staff
For Information: Clarence Bailey, M.D., 1824 Hillandale Road, Durham 27705

February 20

Second District Medical Society Annual Meeting
Place: Ramada Inn, New Bern
Scientific Session—2:00 p.m.; banquet—7:00 p.m., speaker, George Gilbert, M.D., President, North Carolina Medical Society
For Information: Zack J. Waters, M.D., 800 Hospital Drive, New Bern 28560

February 20 & 27

First District Medical Society Symposium—the last of a series of seven meetings

February 20—Current Concepts in Diabetes, and Review of Thyroid Disease

February 27—Medicare and Medicaid; Physician Profile; this also is "Ladies Night"

Sponsors: First District Medical Society; Division of Health Affairs, ECU; in cooperation with Albemarle Human Resources Development System and the North Carolina Regional Medical Program

Place: Queen Anne's Restaurant, Edenton

Time: 4:00-9:00 p.m., including two scientific sessions and dinner

For Information: Miss Patricia Garton, P. O. Box 589, Edenton 27932

March 6-7

Gastrointestinal Endoscopy: Diagnostic & Therapeutic Applications

Sponsor: Division of Gastroenterology, U.N.C. School of Medicine

Speakers will include: Hiromi Shinya, M.D., Beth Israel Hospital, New York, and Col. H. Worth Boyce, Jr., M.C., President, American Society for Gastrointestinal Endoscopy, plus speakers from Bowman Gray, Duke and U.N.C. School of Medicine. The program will utilize workshops, lectures and demonstrations

Eligibility: Enrollment limited

Fee: \$75

For Information: Oscar L. Sapp III, M.D., Associate Dean for Continuing Education, School of Medicine, UNC, Chapel Hill 27514

March 11-15

(With a follow-up meeting on May 17th)

Practical Approaches to Diabetic Care

Place: Carrington Hall

Eligibility: Open to all registered nurses

Fee: \$150.00; James M. Johnston awards available to cover up to \$140.00 of the tuition, on the basis of need

For Information: Patricia Lawrence, R.N., UNC-CH School of Nursing, Chapel Hill 27514

March 14

Malignant Disease Symposium on Carcinoma of the Lung
Sponsors: Department of Surgery and the Office of Continuing Education

For Information: Miss Ann Francis, Administrative Assistant, Office of Continuing Education, School of Medicine, UNC, Chapel Hill 27514

March 15-16

Tenth Annual E. C. Hamblen Symposium in Reproductive Biology and Family Planning. Basic themes: The Management of High-Risk Obstetrics and Newer Advances in the Treatment of Infertility

Sponsor: Department of Obstetrics and Gynecology

Tuition: \$25.00; no charge for residents or students

For Information: Charles B. Hammond, M.D., P. O. Box 3143, Duke University Medical Center, Durham 27710

March 21-23

Hematology and Oncology Post Graduate Course

Place: Duke University School of Medicine

Director: Wayne Rundles, M.D., Professor of Hematology, Duke University

For Information and registration forms: American College of Physicians, 4200 Pine Street, Philadelphia, Pennsylvania 19104

March 25-27

Tutorial Postgraduate Course: Radiology of the Chest

This course is designed both for radiologists in training and those in practice. The tutorial format and limited registration will allow a larger than usual faculty-student ratio and personalized instruction to those enrolled. Guest faculty have been chosen both for their excellence in their respective topics, and for their effective use of the tutorial approach. During one hour tutorial sessions 12 registrants will join one faculty member in a separate quiet room with a bank of viewboxes for organized film reading-discussions, with 10-12 case presentations on a basic subject or two. Registrants are invited to bring interesting cases for consultation with the "experts."

Place: Durham Hotel & Motel, Durham

Credit: 21 hours AMA "Category One" accreditation

Fee: \$200.00

For Information: Robert McLelland, M.D., Department of Radiology, Box 3808, Duke University Medical Center Durham 27710

March 26-28

Cardiac Arrhythmia Course

Place: Duke Hospital Orthopedic Clinic, Room 1367

For Information: Galen Wagner, M.D., Box 3327, Duke University Medical Center, Durham 27710

March 28

Wilson Memorial Hospital Symposium on Obesity, Nutrition & Physical Fitness

Sponsors: Wilson County Medical Society and the North Carolina Academy of Family Physicians

For Information: Gloria Graham, M.D., Wilson Memorial Hospital, Wilson 27893

April 1-2

Postgraduate Course: Obstetrics and Gynecology
Place: Babcock Auditorium
For Information: Emery C. Miller, M.D., Associate Dean
for Continuing Education, Bowman Gray School of
Medicine, Winston-Salem 27103

April 27

Craven-Pamlico Annual Medical Society Symposium
Place: Ramada Inn, New Bern
For Information: Zack J. Waters, M.D., 800 Hospital Drive,
New Bern 28560

May 4-5

Principles of Practical Oxygen Therapy
Sponsors: Department of Anesthesiology in cooperation with
the Office of Continuing Education
For Information: Miss Ann Francis, Administrative As-
sistant, Office of Continuing Education, School of Medi-
cine, UNC, Chapel Hill 27514

May 8-9

Breath of Spring '74—Respiratory Care Symposium
Place: Babcock Auditorium
For Information: Emery C. Miller, M.D., Associate Dean
for Continuing Education, Bowman Gray School of Medi-
cine, Winston-Salem 27103

May 14-16

The Neuro-endocrinology Symposium: Neurobiology of
CNS—Hormone Interaction
Place: UNC Student Union Building, Great Hall
Sponsors: UNC Neurobiology Program and Laboratories
for Reproductive Biology
For Information: Miss Ann Francis, Administrative As-
sistant, Office of Continuing Education, UNC School of
Medicine, Chapel Hill 27514

May 15

Ethel Nash Day Program
Place: Clinic Auditorium Time: 1:00-5:30 p.m.
Sponsor: Department of Obstetrics and Gynecology
For Information: Miss Ann Francis, Administrative As-
sistant, Office of Continuing Education, UNC School of
Medicine, Chapel Hill 27514

May 16-18

Basic Mechanisms in Hypertension
Place: Babcock Auditorium
Sponsor: American Heart Association Basic Science Council
For Information: Emery C. Miller, M.D., Associate Dean
for Continuing Education, Bowman Gray School of Medi-
cine, Winston-Salem 27103

May 28-31

Fourth postgraduate course in Head & Neck Anatomy
Sponsors: Department of Anatomy, School of Medicine, in
cooperation with the Division of Continuing Education,
East Carolina University
Fee: \$125.00; students in residency programs \$75.00
Eligibility: Open to holders of any of following degrees:
M.D., D.D.S., D.M.D., Ph.D.
Credit: Approved for 28 hrs. AAFP elective hours: CE
units also given by Division of Continuing Education.
ECU
For Information: Head & Neck Anatomy Course, ECU Di-
vision of Continuing Education, P. O. Box 2727, Green-
ville 27834

May 29-30

Hypertension: Critical Problems—25th Annual Meeting and
Scientific Sessions, North Carolina Heart Association
Place: Hyatt House and Convention Center, Winston-Salem
Designed especially for nurses and physicians
For Information: North Carolina Heart Association, 1 Heart
Circle, Chapel Hill 27514

June 12-15

Neurology for Practicing Physicians
Place: Babcock Auditorium

Sponsor: American College of Physicians

Fee: Members, residents and research fellows \$120; non-
members \$175; associates \$60.

For Information: Emery C. Miller, M.D., Associate Dean
for Continuing Education, Bowman Gray School of Medi-
cine, Winston-Salem 27103

July 29-August 2

2nd Annual Beach Workshop: Selected Topics in General
Internal Medicine

Sponsors: Bowman Gray, Duke and UNC Schools of Medi-
cine, in conjunction with the Medical University of South
Carolina

Place: St. Johns Inn, Myrtle Beach, South Carolina

Fee: \$100

For Information: Emery C. Miller, M.D., Associate Dean
for Continuing Education, Bowman Gray School of Medi-
cine, Winston-Salem 27103

In Contiguous States

February 21-23

Annual Meeting of the Virginia Chapter of the American
Academy of Pediatrics

Place: Colonial Williamsburg

Program: Friday night banquet guest speaker—Dr. James B.
Gillespie, President, American Academy of Pediatrics.
Friday and Saturday scientific sessions include: New
Trends in Management of Respiratory Distress; Support-
ive Therapy for the Child with Inborn Error of Metabo-
lism; Non-Bacterial Respiratory Tract Infections; Sudden
Infant Death Syndrome; Viral Vaccines; Adaption in
School of the Child with Borderline Cerebral Handicaps.
For Information: James H. Stallings, Jr., M.D., 6503 North
29th Street, Arlington, Virginia 22213.

March 7-9

Sports Medicine Problems in All Age Groups

Place: Page Auditorium, Duke University, Durham

ANESTHESIOLOGY PLACEMENT SERVICE

For Locations in North Carolina desir-
ing the services of an anesthesiologist and
for anesthesiologists wishing to locate or
relocate in North Carolina

CONTACT:

Placement Service

N. C. Society of Anesthesiologists

Department of Anesthesiology

North Carolina Memorial Hospital

Chapel Hill, North Carolina 27514

Sponsor: American Academy of Orthopaedic Surgeons
 Fee: \$150.00; residents \$50.00
 For Information: The American Academy of Orthopaedic Surgeons, 430 North Michigan Avenue, Chicago, Illinois 60611

March 10-14

Postgraduate Course in Gastrointestinal Radiology
 Place: Williamsburg Conference Center, Williamsburg, Virginia

Sponsors: Department of Radiology and the Department of Continuing Medical Education

Fee: \$175.00; \$75.00 for residents

For Information: Department of Continuing Education, Medical College of Virginia, Box 91, MCV Station, Richmond, Virginia 23298

April 5-6

AMA-Southeast Regional Mental Health Conference
 Place: Marriott Hotel, Atlanta, Georgia

Sponsors: AMA Council on Mental Health and the committees responsible for mental health in the state medical associations of Florida, Georgia, Kentucky, North Carolina, South Carolina and Tennessee

Fee: \$25.00

For Information: Philip G. Nelson, M.D., Medical Pavilion, Greenville 27834

April 16

Fourth Annual Charles W. Thomas Lecture
 Place: George Ben Johnston Auditorium

Sponsor: Division of Connective Tissue Diseases

For Information: Department of Continuing Education, Medical College of Virginia, Box 91, MCV Station, Richmond, Virginia 23298

April 20-24

"Selection of Materials for Reconstructive Surgery," the Sixth International Biomaterials Symposium

Designed to bring together clinicians in orthopedics, oral surgery, plastic and reconstructive surgery with leading researchers in biomaterials, biomechanics, biophysics and experimental surgery

Place: Clemson University, Clemson, South Carolina

For Information: Dr. Samuel F. Hulbert, Dean of Engineering, Tulane University, New Orleans, Louisiana 70118

May 6-9

The Treatment of Coronary Syndromes

Place: Royal Coach Motor Hotel, Atlanta, Georgia

Sponsors: American Heart Association Council on Clinical Cardiology and the Department of Medicine of Emory University School of Medicine

For Information: Miss Mary Anne McInerney, Director, Department of Continuing Education Programs, American College of Cardiology, 9650 Rockville Pike, Bethesda, Maryland 20014

Items submitted for listing should be sent to: WHAT? WHEN? WHERE?, P. O. Box 8248, Durham, NC, 27704, by the 10th of the month prior to the month in which they are to appear.

News Notes from the—

BOWMAN GRAY SCHOOL OF MEDICINE WAKE FOREST UNIVERSITY

One associate professor and five assistant professors are among those newly appointed to the faculty of the Bowman Gray School of Medicine.

Dr. Nitya R. Ghatak, associate professor of pathology, is a native of India and holds the M.B.B.S. degree from Nilratan Sircar Medical College of the

Rondomycin (methacycline HCl)

CONTRAINDICATIONS

Hypersensitivity to any of the tetracyclines
WARNINGS Tetracycline usage during tooth development (last half of pregnancy to eight years) may cause permanent tooth discoloration (yellow-gray-brown), which is most common during long-term use but has occurred after repeated short-term courses. Enamel hypoplasia has also been reported. **Tetracyclines should not be used in this age group unless other drugs are not likely to be effective or are contraindicated.**

Usage in pregnancy (See above **WARNINGS** about use during tooth development). Animal studies indicate that tetracyclines cross the placenta and can be toxic to the developing fetus (often related to retardation of skeletal development). Embryotoxicity has also been noted in animals treated early in pregnancy.

Usage in newborns, infants, and children (See above **WARNINGS** about use during tooth development).

All tetracyclines form a stable calcium complex in any bone-forming tissue. A decrease in fibula growth rate observed in premature given oral tetracycline 25 mg/kg every 6 hours was reversible when drug was discontinued.

Tetracyclines are present in milk of lactating women taking tetracyclines.

To avoid excess systemic accumulation and liver toxicity in patients with impaired renal function, reduce usual total dosage and if therapy is prolonged consider serum level determinations of drug. The anti-anabolic action of tetracyclines may increase BUN. While not a problem in normal renal function, in patients with significantly impaired function higher tetracycline serum levels may lead to azotemia, hyperphosphatemia, and acidosis.

Photosensitivity manifested by exaggerated sunburn reaction has occurred with tetracyclines. Patients apt to be exposed to direct sunlight or ultraviolet light should be so advised, and treatment should be discontinued at first evidence of skin erythema.

PRECAUTIONS If superinfection occurs due to overgrowth of nonsusceptible organisms including fungi, discontinue antibiotic and start appropriate therapy.

In venereal disease when coexistent syphilis is suspected, perform darkfield examination before therapy and serologically test for syphilis monthly for at least four months.

Tetracyclines have been shown to depress plasma prothrombin activity; patients on anticoagulant therapy may require downward adjustment of their anticoagulant dosage.

In long-term therapy perform periodic organ system evaluations (including blood, renal, hepatic).

Treat all Group A beta-hemolytic streptococcal infections for at least 10 days.

Since bacteriostatic drugs may interfere with the bactericidal action of penicillin, avoid giving tetracycline with penicillin.

ADVERSE REACTIONS Gastrointestinal (oral and parenteral forms) anorexia, nausea, vomiting, diarrhea, glossitis, dysphagia, enterocolitis, inflammatory lesions (with monilial overgrowth) in the anogenital region.

Skin maculopapular and erythematous rashes, exfoliative dermatitis (uncommon). Photosensitivity is discussed above (See **WARNINGS**).

Renal toxicity rise in BUN, apparently dose related (See **WARNINGS**).

Hypersensitivity urticaria, angioneurotic edema, anaphylaxis, anaphylactoid purpur, pericarditis, exacerbation of systemic lupus erythematosus.

Bulging fontanelles reported in young infants after full therapeutic dosage, have disappeared rapidly when drug was discontinued.

Blood hemolytic anemia, thrombocytopenia, neutropenia, eosinophilia.

Over prolonged periods, tetracyclines have been reported to produce brown-black or crossopscopic discoloration of thyroid glands; no abnormalities of thyroid function studies are known to occur.

USUAL DOSAGE Adults—600 mg daily, divided into two or four equally spaced doses. More severe infections: an initial dose of 300 mg followed by 150 mg every six hours.

300 mg every 12 hours. Gonorrhea. In uncomplicated gonorrhea, when penicillin is contraindicated, Rondomycin (methacycline HCl) may be used for treating both males and females in the following clinical dosage schedule: 900 mg initially, followed by 300 mg q.i.d. for a total of 5.4 grams.

For treatment of syphilis, when penicillin is contraindicated, a total of 18 to 24 grams of Rondomycin (methacycline HCl) in equally divided doses over a period of 10-15 days should be given. Close follow-up including laboratory tests is recommended.

Eaton Agent pneumonia: 900 mg daily for six days.

Children—3 to 6 mg/lb/day divided into two to four equally spaced doses.

Therapy should be continued for at least 24-48 hours after symptoms and fever have subsided.

Concomitant therapy Antacids containing aluminum, calcium or magnesium impair absorption and are contraindicated. Food and some dairy products also interfere. Give one hour before or two hours after meals. Pediatric oral dosage forms should not be given with milk formulas and should be given at least one hour prior to feeding.

In patients with renal impairment (see **WARNINGS**), total dosage should be decreased by reducing recommended individual doses or by extending time intervals between doses.

In streptococcal infections, a therapeutic dose should be given for at least 10 days.

SUPPLIED Rondomycin (methacycline HCl) 150 mg and 300 mg capsules, syrup containing 75 mg/5 cc methacycline HCl.

Before prescribing, consult package circular or latest PDR information.

Rev. 6



WALLACE PHARMACEUTICALS
 CRANBURY, NEW JERSEY 08512

University of Calcutta. He was an intern and resident in internal medicine at the Nilratan Sircar Medical College and was a rotating intern at Griffin Hospital, Darby, Conn. He took residency training in pathology at Montefiore Hospital and Medical Center in New York City, where he was also a trainee in neuropathology.

Before joining the Bowman Gray faculty, he was an associate neuropathologist at Montefiore Hospital and Medical Center and an assistant professor of pathology at the Albert Einstein College of Medicine.

Also receiving appointments were Dr. Jerome J. Cunningham, assistant professor of radiology (uro-radiology); Dr. Jack L. Mason, assistant professor in the medical school's allied health program; Dr. Dixon M. Moody, assistant professor of radiology (neuroradiology); Dr. Darwin W. Peterson, assistant professor of physiology; and Dr. Roger F. Parker, assistant professor of physiology and pharmacology.

Also, Daniel R. Beerman, instructor in pediatrics (social work).

* * *

Dr. Felda Hightower, professor of surgery, has been elected treasurer of the Southern Surgical Association for the 10th year. Dr. Hightower also is serving his 10th year as editor of *Transactions of the Surgical Association*.

* * *

Dr. Hugh B. Lofland, professor of pathology, has been elected to a three-year term on the Executive Committee of the Council on Arteriosclerosis, American Heart Association.

* * *

Dr. Richard B. Patterson, associate professor of pediatrics, has been appointed to the Governor's Commission on Sickle Cell Syndrome.

* * *

Dr. Lawrence R. DeChatelet, associate professor of biochemistry, chaired a session on "Structure, Function and Biochemical Activities of RE Cells" at the 10th annual meeting of the Reticuloendothelial Society, Dec. 5-8 in Williamsburg, Va. He also presented a paper entitled "Superoxide Dismutase (SOD) Activity in Phagocytic Cells" during the meeting.

* * *

Dr. Frank C. Greiss, Jr., professor and chairman of the Department of Obstetrics and Gynecology, was chairman of the Section on Obstetrics at the Southern Medical Association meeting in San Antonio, Tex. He was moderator for a panel on "Sexual Function during Pregnancy" during the meeting.

* * *

Dr. Henry S. Miller, Jr., professor of medicine, presented a paper entitled "Effect of Exercise on Circulation" during the 25th annual meeting of the American Heart Association in Atlantic City, N. J.

Dr. B. Moseley Waite, associate professor of biochemistry, presented a seminar entitled "Heparin Stimulated Release of Phospholipase A₁" to the Department of Nutrition at the Harvard School of Public Health in November.

News Notes from the—

UNIVERSITY OF NORTH CAROLINA DIVISION OF HEALTH AFFAIRS

The following appointments have been made in the School of Medicine:

David L. Ingram, assistant professor, Department of Pediatrics, has been associated with The Children's Hospital Medical Center and Beth Israel Hospital. He holds the A.B. from Harvard University and M.D. from Yale University.

Anthony Cole, visiting instructor, Department of Family Medicine, is a native of England and received his medical training at King Edward VI School and St. Mary's Hospital, University of London.

Frances C. Driver, instructor, Department of Psychiatry, and assistant director, Day Hospital, holds the B.S. from Montana State University and the M.D. from the University of Rochester. She spent the last three years as a resident at N. C. Memorial Hospital.

School of Dentistry:

Harold B. Wise, assistant professor, Department of Operative Dentistry, has been in private practice in Fort Worth, Texas for the past four years. He received his undergraduate degree from Texas Christian University and his dental training at Baylor University College of Dentistry.

School of Nursing:

Margaret E. Campbell, assistant professor, comes to UNC from UNC-Greensboro, and received her B.S. and M.S. in nursing from the University here.

* * *

A research fellowship has been established in the UNC Department of Parasitology in Chapel Hill by Becton, Dickinson and Co. of the Research Triangle Park, N. C.

The \$20,000 award will support a doctor of public health candidate in laboratory practice for the three year program. The first fellowship will be announced in 1974.

* * *

Dr. Bernard G. Greenberg, dean of the UNC School of Public Health and Kenan Professor of Biostatistics here, has been elected to the Council of the Institute of Medicine, National Academy of Sciences.

The Council is the governing body of the Institute of Medicine and consists of 21 members chosen from among the current membership of 215. Organized in 1971 under the National Academy of Sciences, the

Institute is concerned with the protection and advancement of the health and medical professions and sciences, and the promotion of biomedical research and development.

The Council of the Institute of Medicine meets every two months to guide the work of the Institute and to plan its program and policy in conjunction with the Governing Board of the National Research Council.

* * *

Richard Shachtman, biostatistician in the School of Public Health, has been awarded a \$32,820 National Institutes of Health grant to study the long-term complications of induced abortions.

Shachtman is analyzing data collected on 948 women whose first pregnancies were either carried to term or terminated by legal abortions. He will study the relationships between abortions and future pregnancies. In his research he will use a Markov Chain, a statistical technique which treats data in chronological fashion in order to test whether certain biological factors are dependent on other biological happenings.

Shachtman said that they hope to provide a description of these interrelationships, a tool for prediction and answers to some questions concerning the risks of abortions.

* * *

Dr. Bernard G. Greenberg, dean of the UNC School of Public Health, was a consultant to the World Health Organization in Geneva during the beginning of December. The sessions Greenberg attended were part of a conference on family planning statistics.

* * *

The following resignations have been announced in the School of Medicine:

Howard D. Stowe, associate professor, Department of Pathology, resigned to accept a position in Auburn, Alabama.

Jean L. Gueriguian, assistant professor, Department of Pharmacology, resigned to accept a position at the University of Minnesota at Duluth.

News Notes from the—

DUKE UNIVERSITY MEDICAL CENTER

Ten seniors and six juniors in the School of Medicine have been elected to memberships in Alpha Omega Alpha, the honorary medical fraternity. Presentations of certificates and keys were made at the Pound Sterling Restaurant in Durham on Tuesday, Nov. 13, at the organization's annual banquet.

In addition, a faculty membership was conferred on Dr. D. Bernard Amos, James B. Duke Professor and director of the Division of Immunology, and

alumni memberships were presented to Dr. Nicholas G. Georgiade, professor of plastic, maxillofacial and oral surgery, Dr. Raymond W. Postlethwait, professor of general and thoracic surgery, and Dr. A. Jack Tannebaum, an internist in private practice in Greensboro.

Professor Guido Calabresi, who holds the John Thomas Smith chair at Yale Law School, was guest speaker at the banquet as Visiting Professor of Legal Medicine.

Alpha Omega Alpha is composed of medical students who have demonstrated leadership and academic promise of future achievement and alumni faculty or honorary members who have distinguished themselves in medical teaching, research or practice.

Seniors elected were:

Robert Woodward Downs of Greenville, S. C.; Isabelle Faeder, James William Mold and Richard Alan Hopkins of Durham; William Elwood Garrett Jr. of Roxboro; Arthur Garson Jr. of New York City; Robert Woodrow Gilbert Jr. of Elko, Ga.; Phyllis Carolyn Leppert of Ridgewood, N. J.; Steve Andrew Paris of Roscindale, Mass.; and John Glen Scott of Tillar, Ark.

Juniors elected were Michael Joseph Borowitz of Bronx, N. Y.; Michael John Jobin of Sommerville, N. J.; Donald Norman Kapsch of Boca Raton, Fla.; Robert William Novak of Berea, Ohio; Harry Rissler Phillips III of Spartanburg, S. C.; and Stanley Glen Rockson of New York City.

* * *

Dennis E. Klima, administrator of the Eye Center and assistant director of the hospital since September of 1971, has resigned to accept the post of assistant administrator of Memorial Hospital in Easton, Md.

C. J. "Cy" Rodio, former unit administrator of the medical unit and manager of the Medical Outpatient Clinic, has been named to succeed Klima as assistant administrative director of the hospital and administrator of the Eye Center.

* * *

Wallace E. Jarboe, director of Hospital Planning Studies since February 1971, has been named director of the newly established Hospital Project Management Office (HPMO).

The new office will centralize all activities, from planning through construction to occupation, for Duke's new \$91 million hospital.

Jarboe's appointment was formalized with the University Board of Trustees' authorization of funding for the office. At the same time the trustees approved retention of an architectural firm for the hospital project.

In addition to Jarboe and three administrative support people, the office will have four other staff positions, known as assistant directors for administration, finance, architecture and engineering.

Larry Nelson, currently architect for the Medical Center Planning Office, will become the assistant

What's in the future for mental health care and how will it affect you?

Your guides into the future: many prominent experts including Drs. Ewald Busse and J.M. Stubblebine. Topics you'll cover: the role of private and public sectors in mental health care; PSROs; health insurance coverage; therapeutic trends; and service capabilities of state and local facilities.

Do plan to attend this enlightening first conference sponsored by the American Medical Association Council on Mental Health and the State Association committees responsible for mental health in the states of Florida, Georgia, Kentucky, North Carolina, South Carolina, and Tennessee. Co-sponsors are the Southern Regional Education Board, District Branches of the American Psychiatric Association and the State Chapters of the American Academy of Physicians in the above six states.

Acceptable for 8 credit hours in Category 1 for the Physician's Recognition Award of the AMA and approved for 8 prescribed hours by the AAFP.

Register Now!

AMA-Southeast Regional Mental Health Conference
Marriott Hotel / Atlanta, Georgia
April 5-6, 1974

Return to: Dept. of Mental Health; AMA; 535 N.
Dearborn St.; Chicago, Ill. 60610

- ☐ **Yes...**please send me details on the AMA-Southeastern Regional Mental Health Conference in Atlanta, April 5-6.
- ☐ Registration fee of \$25 enclosed. (Make check payable to AMA)
- ☐ I will pay at conference.

Name _____

Address _____

Affiliation _____

City/State/Zip _____

rector for architecture. Appointments to the other positions have not been announced.

Immediately prior to coming to Duke, Jarboe was a senior medical planner and a vice president of Georgetown Consultants, a Washington consulting firm specializing in health-care management and facility planning. Prior to that he was an Air Force officer whose 30-year career was largely in hospital and health-care administration.

For five years he was chief of the facilities division, office of the Air Force Surgeon General, during which time he was responsible for planning, programming and justifying medical facilities world-wide to the Air Staff, Department of Defense, Bureau of the Budget and the Congress.

* * *

Norma L. Harris, nurse clinician on the Renal Transplantation Team, has been nominated by the N. C. State Nurses' Association for the first American Nurses' Association Honorary Nurse Practitioner Award. The award winner will be announced in June.

In support of Miss Harris' nomination, 27 doctors, nurses and patients who have worked with or been cared for by her over the years have written a stack of testimonial letters telling of her kindness, concern, inspiration and extreme competence.

A new breathing mixture for deep sea diving which could allow men to tap the vast oil resource of the ocean floor beyond the continental shelf has been successfully tested in the hyperbaric chamber here.

The mixture may allow men to dive to greater depths than ever before, get there faster and arrive in much better physical and mental condition than now possible.

The last in the series of experimental dives was completed earlier this month, with four men diving to 1,000 feet in only 33 minutes—the fastest compression time to that depth ever used—breathing a new mixture of helium, oxygen and nitrogen.

They arrived at that simulated depth in the 100-foot pressure chamber with none of the usual loss of mental and physical capacity that afflicts divers breathing the traditional helium-oxygen mixture, and they returned to surface pressure in a little over 96 hours. This compares to the usual 14-day decompression period used by the U. S. Navy for dives to 1,000 feet.

"To get men down to that depth in only 33 minutes and to end up with men who are functional and capable is really quite remarkable and will reopen the search for new depths to which man can go," said Dr. Peter B. Bennett, professor of anesthesiology and director of the project.

Month in Washington

Little noticed amid congressional confusion in attempting to deal with the energy crisis was the passage of a major health bill shortly before adjournment. The bill provides \$375 million over five years to support the development of Health Maintenance Organizations (HMO's) across the country.

If signed into law by the President, the HMO legislation will go far in determining both consumer and provider acceptance of pre-paid group health care. Despite a substantial flow of federal dollars into the experimental program, HMO's are not expected to encounter easy sailing. Ardent supporters of the program admit the trial period will be a rough one and caution against over optimism.

The speculation is that the President will sign the bill inasmuch as the money provided is not far over what the Administration originally requested, though the bill is much broader in scope than the President wished.

Two key provisions of the \$805 million bill first

approved by the Senate earlier this year were deleted or watered-down in conference enough to make the measure more palatable to the administration. The bill would have authorized federal subsidization of HMO premium costs for people who couldn't afford a part of the cost. The other controversial Senate provision would have created an independent Commission on Quality Health Care Assurance to supervise the HMO program. The compromise bill vests this responsibility with the Assistant Secretary of HEW for Health.

To qualify for federal aid, HMO's must meet a long list of federal standards of minimum benefits, stay open 24 hours a day, provide open enrollment and conform to numerous other requirements. Incentives are provided to attract people from poor and rural areas.

The Senate provision authorizing grants to assist HMO's in meeting operating deficits during the initial three years of operation was knocked out of the bill.

but a loan fund was retained to aid HMO's meeting "a portion of initial operating costs in excess of gross revenues."

Co-payments were barred under the Senate bill. However the conference agreed to allow HMO's to charge nominal co-payments, but not to the extent it could be considered a barrier to seeking treatment. The conference committee said the co-payments are aimed at enabling an HMO "to market benefit package at a competitive price."

The final bill requires larger employers to offer workers an HMO option when existing contracts for health insurance expire provided that a qualified HMO is operating in the area.

The bill does not provide a specific number of HMO's, but the bill's legislative history indicates the Congress had in mind around 100 programs.

* * *

Rep. John Rarick (D., La.), principal congressional sponsor of legislation to repeal the Professional Standards Review Organization (PSRO) program, dispatched a letter to all members of the House asking their support.

In his letter, Rarick said PSRO "is the hottest controversy facing medical doctors and their patients. The American Medical Association's prestigious House of Delegates yesterday voted to seek congressional repeal of this controversial peer-review law that goes into effect on January 1, 1974."

Rarick quoted AMA President-elect Malcolm C. Todd, MD, as calling PSRO "... the greatest threat to the private practice of medicine of any piece of legislation ever passed by congress."

The PSRO section of Medicare was added by the Senate and was never adequately debated, the lawyer said. "The House did not even hold public hearings on this issue."

Rarick cited the Wall Street Journal's statement about PSRO—that points out that "the controversial legislation is laced with pointed references to 'new regulations imposed on' medical practitioners. It requires physicians to open their private files and hospital records to outside inspectors. Strong financial penalties are provided for physicians who fail to comply."

Rarick wrote that he is concerned over the effect of the legislation on private medical practice in this country. "I am convinced that the medical profession has done an outstanding job of policing its own profession and establishing a high code of ethics. It simply does not make sense to bog down the medical profession with further government intervention that threatens the relationship between doctor and patient."

* * *

The first round of congressional hearings on National Health Insurance (NHI) concluded following a week of testimony from experts in the health-economic field who laid a general philosophical foundation

for full-scale legislative sessions early in the new year.

The hearings by the House Health Subcommittee were the opening gun in what promises to be a busy 1974 in Congress on the issue of an NHI bill.

The Subcommittee, headed by Rep. Paul Rogers (D., Fla.), has charted six weeks of further testimony in January and February that will consider specific legislative proposals. The House Ways and Means Committee also is slated to explore NHI sometime next year. Senate sessions are expected to open during the winter or spring by both Senate Finance and Senate Labor and Public Welfare Committees.

The next major development in the field will be the formal disclosure of the details of the Administration's new plan, expected to be unveiled in President Nixon's January State of the Union speech to Congress and probably in a special message to Congress on health.

The new Administration plan will be more liberal than the previous one, but it will continue to be based on the principle of requiring employers to furnish comprehensive health insurance to their workers. The major changes are a broad catastrophic provision tied to income and federal subsidization of premiums for all poor people. Medicare and Medicaid, apparently, would lose their separate identities and become part of the new program under the jurisdiction of the Public Health Service.

According to Budget Director Roy Ash, NHI should be kept to a size that will avoid creating more demands for health services than can be met with existing resources. Otherwise, he said in an interview with the *New York Times*, there is a danger that the sole accomplishment would be an increase in the prices of health services.

Many of the witnesses before Roger's Subcommittee predicted that a financing mechanism for NHI without other provisions would add to inflation of health care costs without much impact, if any, on the health of Americans. Other experts questioned whether any type of NHI would improve health, contending that environment, life styles, poverty, etc., are to blame for poor health conditions.

The closest approach to a consensus was that too much hope should not be placed in an NHI program to solve the health care problems of the nation.

One of the final witnesses, Robert J. Myers, former Chief Actuary of the Social Security Administration, denied there has been any crisis in health care costs, asserting that health has simply been caught up in the "general price and wage inflation resulting from the Viet Nam war, plus the more rapid wage increases of hospital personnel . . . plus the historical trend of medical care costs rising more rapidly than the general price level. . . ."

Myers said there is "far too much" first dollar coverage in private health insurance and not enough catastrophic coverage. Catastrophic, he said, "is

sorely needed by most Americans" and should vary with income and assets.

"I am convinced that cost-sharing provisions, properly designed can have a beneficial effect in preventing overutilization without being an unjust economic barrier that will result in preventing the insured from receiving necessary medical care. . . ."

Under a sweeping NHI such as proposed by Sen. Edward Kennedy (D., Mass.), and labor "the providers of services might rebel if the financial screws on them are tightened too rapidly or too much, or the beneficiaries might rebel if they are regimented or controlled too much as to their desires for medical services," Myers told the subcommittee.

Herbert Denenberg, Pennsylvania Commissioner of Insurance, asked for strict cost and quality controls in any NHI program. "Pumping more dollars into a health care system with serious structural shortcomings will aggravate present problems."

Earl Brian, MD, California Secretary of Health, stressed that the cooperation of organized medicine and other health providers is necessary for an NHI program to work. Otherwise, the nation's health care system will deteriorate, he said. As many responsibilities as possible should be left to the providers, according to Dr. Brian. He cited the cooperation of organized health groups in California despite state controls that have "alienated the health care community." The demand for medical care will always exceed the dollars available, he said, so any program must contain restrictions which relate it to the free market system. The present concern over Professional Standards Review Organizations is only a harbinger of what would happen if a bureaucratic NHI were enacted and demonstrates the "imprudence of permanent government controls," he asserted.

* * *

Sen. Edward Kennedy's Health Subcommittee hearings on the drug industry lived up to their explosive expectations with HEW Secretary Casper Weinberger throwing the first bomb by announcing that the Administration would propose a cost-saving drug plan for Medicare and Medicaid patients under which reimbursement would be limited to "the lowest cost at which the drug is generally available."

Estimating the savings at \$25 to \$60 million a year, the HEW proposal was a blow to the pharmaceutical industry which viewed it as a step toward generic prescribing and a setback to the brand name concept. Congress would have to approve the proposal, however.

Under questioning from subcommittee members, Weinberger was vague about how the program would work, but emphasized that physicians would remain free to prescribe as they choose. Sen. Kennedy praised the proposal. Sen. Gaylord Nelson (D. Wis.) said the HEW recommendation "must be only the first step in a massive intrusion by the federal government into the prescribing habits of physicians."

PRESCRIBING INFORMATION

Antiminth (pyrantel pamoate) Oral Suspension

Actions. Antiminth (pyrantel pamoate) has demonstrated anthelmintic activity against *Enterobius vermicularis* (pinworm) and *Ascaris lumbricoides* (roundworm). The anthelmintic action is probably due to the neuromuscular blocking property of the drug.

Antiminth is partially absorbed after an oral dose. Plasma levels of unchanged drug are low. Peak levels (0.05-0.13 µg/ml.) are reached in 1-3 hours. Quantities greater than 50% of administered drug are excreted in feces as the unchanged form, whereas only 7% or less of the dose is found in urine as the unchanged form of the drug and its metabolites.

Indications. For the treatment of ascariasis (roundworm infection) and enterobiasis (pinworm infection).

Warnings. *Usage in Pregnancy:* Reproduction studies have been performed in animals and there was no evidence of propensity for harm to the fetus. The relevance to the human is not known.

There is no experience in pregnant women who have received this drug.

Precautions. Minor transient elevations of SGOT have occurred in a small percentage of patients. Therefore, this drug should be used with caution in patients with pre-existing liver dysfunction.

Adverse Reactions. The most frequently encountered adverse reactions are related to the gastrointestinal system.

Gastrointestinal and hepatic reactions: anorexia, nausea, vomiting, gastralgia, abdominal cramps, diarrhea and tenesmus, transient elevation of SGOT.

CNS reactions: headache, dizziness, drowsiness, and insomnia. Skin reactions: rashes.

Dosage and Administration. *Children and Adults:* Antiminth Oral Suspension (50 mg. of pyrantel base/ml.) should be administered in a single dose of 11 mg. of pyrantel base per kg. of body weight (or 5 mg./lb.); maximum total dose 1 gram. This corresponds to a simplified dosage regimen of 1 cc. of Antiminth per 10 lb. of body weight. (One teaspoonful = 5 cc.)

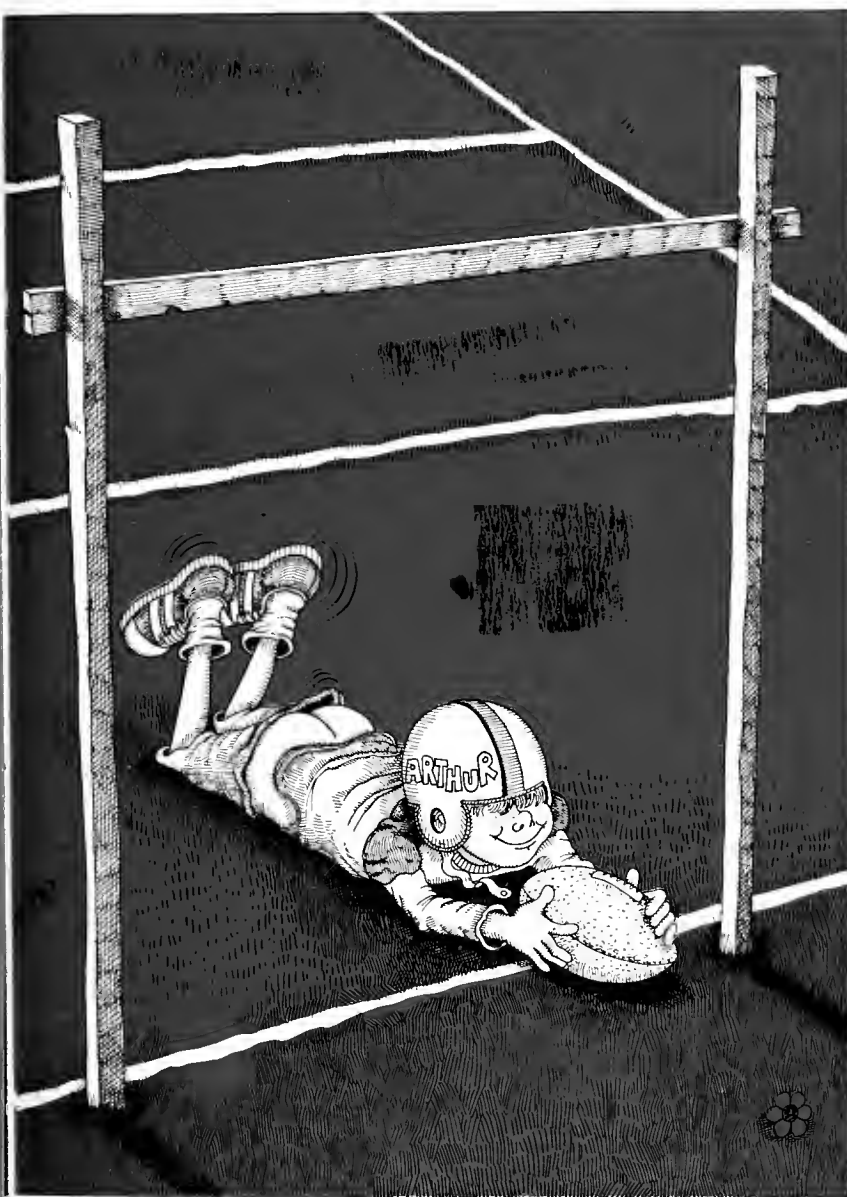
Antiminth (pyrantel pamoate) Oral Suspension may be administered without regard to ingestion of food or time of day; and purging is not necessary prior to, during, or after therapy. It may be taken with milk or fruit juices. Because of limited data on repeated doses, no recommendations can be made.

How Supplied. Antiminth is available as a pleasant tasting caramel-flavored suspension which contains the equivalent of 50 mg. pyrantel base per ml., supplied in 60 cc. bottles.

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WORMS BLITZED



A single dose of Antiminth (1 cc. per 10 lbs. of body weight, 1 tsp./50 lbs. — maximum dose, 4 tsp.=20 cc.) offers highly effective control of *both* pinworms and roundworms.

Antiminth has been shown to be extremely well tolerated by children and adults alike in clinical studies.* Pleasantly caramel-flavored, it is non-staining to teeth and oral mucosa on ingestion... doesn't stain stools, linen or clothing.

One prescription can economically treat the entire family.

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with a single, non-staining dose of**

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equivalent to 50 mg. pyrantel/ml.

ORAL SUSPENSION

Please see prescribing information on facing page.

The first day's session featured charges that drug companies are monopolistic, keep prices jacked high, and spend huge amounts on advertising. Physicians were described as inept and too generous prescribers of drugs influenced inordinately by advertising and drug detail men. It was implied that 100 deaths a day due to adverse drug reactions were the fault of the drug industry and the prescribing physicians.

Sen. Gaylord Nelson (D., Wis.), a subcommittee member, urged that prescription drug advertising be banned and trade names eliminated. Consumer advocate Ralph Nader agreed and recommended patent restriction.

In an opening statement, Kennedy said the hearings are designed to "search for legislative solutions to the problems surrounding the way drugs are developed, marketed and used in this country." He said "Too many physicians are prescribing too many drugs on the basis of too little information . . . such irrational prescribing is a product of physician ignorance, not malice. . . ."

Kennedy's subcommittee had never before asserted broad jurisdiction in the drug field. The hearings were viewed as a stake-out to this aspect of health and government, and also as a bow to Nelson who has been investigating the drug industry for years and is its strongest critic on Capitol Hill. Nelson is a new member of the Kennedy subcommittee. His previous forum was a Senate small business subcommittee.

James H. Sammons, MD, Chairman of the Board of the American Medical Association, told the subcommittee that in the heat of controversy it should be emphasized that "Today there are a large number of drug preparations available through a complex delivery system replete with checks and balances provided by industry, the Food and Drug Administration, physicians, pharmacists, and in some instance allied health personnel."

Dr. Sammons continued, "It is not surprising that this complex and important system carries with it complex problems that different groups within the system perceive differently . . . simple solutions for the management of our problems are not realistic."

The AMA official said the reduction in funding for research investigators could have an adverse effect on development of improved drugs. The complexity of FDA procedures "is becoming self-defeating and some new approaches are required if we are to be able to provide new and useful therapeutic agents to alleviate existing maladies."

Whatever is done, Dr. Sammons said, "the physician must be able to prescribe the drug in dosage and strength deemed appropriate for his patient. . . ."

"Where appropriate, we believe the physician should prescribe the least expensive product," Dr. Sammons testified. "But the generic name on the bottle is not a guarantee of equivalence, nor for that matter does a generic prescription even guarantee t

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GEORGE S. FULTZ, JR., M.D.

GRAENUM R. SCHIFF, M.D.

Under Phase IV Cost of Living Council regulations, physicians must maintain a schedule showing prices in effect on December 28, 1973, for services which comprise 90% of their revenues, and the subsequent changes and dates. "A conspicuous and easily readable sign" must be posted stating the availability and location of the price schedule.

PHASE IV REQUIRES A SIGN BE POSTED.

FOR YOUR CONVENIENCE WE

OFFER THE SIGN BELOW

**CLIP AND POST IN
YOUR OFFICE**

To my patients . . .

In Compliance with Cost
of Living Council regulations,
a schedule of my fees
is available at this office
upon request.

CLIP ALONG DOTTED LINE

(Signature)

Member, North Carolina Medical Society

the patient that he will receive the least expensive product."

C. Joseph Stetler, President of the Pharmaceutical Manufacturers Association, testified that, "What the secretary is proposing represents an extraordinarily radical approach to health care, one which may give the appearance of providing first class medical care at less cost, but which will either require Medicare and Medicaid beneficiaries to accept inferior products or force them to pay the cost of first class medicines from their own household budgets."

Stetler said the proposal might have some merit if therapeutic equivalence of drugs could be assured, "but the published evidence is almost entirely on the other side. Reports of the clinical inequivalence of drugs sold under the same generic name are increasing as are quality control failures."

On another tack, Stetler said new drug discoveries have been a major contributor to improving health care, and that drug prices have held stable in a period of soaring inflation.

But, he warned, America is falling behind foreign competitors in the rate of pharmaceutical innovation, adding that the industry's pattern of discovery of new

drugs and the stable prices of medicines are threatened by proposals to reduce incentives for drug producers to continue their massive research programs.

"Price setting, dilution of patent rights, or a government takeover of research and development or promotional activities," suggested by some, would be self-defeating and lead to higher prices and lower productivity, Stetler said.

Although the industry's dollar investment in research is continuing to climb, Stetler testified that fewer American pharmaceutical firms are sponsoring such activities due, in part, to the tangle of government delays and regulations.

In his slashing testimony, Sen. Nelson said the AMA "has cooperated in creating confusion" and has been "disastrous in this field because the custodians of health care in this country are the guide to us on what good medical practice is." The AMA "has done more damage to the good practice of drug prescribing than if it did not exist at all," Nelson said. The AMA's drug manual was "degraded" due to pressure from drug companies . . . "For money! It is as simple as that," he asserted.

Nader accused the industry of "price gouging and



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causing serious harm to tens of thousands of people that is unparalleled history."

The hearings will resume later this winter and continue through to summer.

* * *

The Administration has moved to set clear fuel priorities in the health field as Congress was warned by health leaders that emergency care, drugs and devices and hospital care could be severely affected unless sufficient fuel is made available this winter.

Immediately following a hastily scheduled one-day hearing before the Senate Health Subcommittee, William E. Simon, head of the Federal Energy Office, said the pharmaceutical industry will get all the fuel it needs for production and research in order to maintain adequate supplies of essential drugs and medical supplies.

A spokesman for the American Medical Association testified there is a critical need to make special provisions for an adequate supply of motor fuel to meet the needs of medicine. J. Cuthbert Owens, MD, a member of the AMA's Commission on Emergency Medical Services, said, "Physicians, nurses, life support personnel, rescue workers, and ambulances and

other emergency motor vehicles must have a sufficient and continuous supply of gasoline to insure the provision of prompt care for the ill and injured. In addition, adequate fuel must be available to health care institutions, as well as to suppliers of necessary medical equipment and supplies."

Leo J. Gehrig, MD, Vice President of the American Hospital Association, said there is no federal natural gas allocation program for health care institutions.

"This substantial area of potential energy shortages significantly magnifies the effect of shortages of other fossil fuels on hospitals," Dr. Gehrig told the subcommittee. The proposed regulations published on December 13, 1973, providing for mandatory allocation of middle distillates, allow hospitals only 100 per cent of their 1972 base period volume, he pointed out. "With increasing natural gas interruptions there is need for hospitals to receive 100 per cent of current fuel requirements," Dr. Gehrig said.

"The hospitals of this country must be provided the priority and supply of energy sources to permit them to deliver vital services to patients," Gehrig said.

Book Review

The Power and the Frailty. By Jean Hamburger. 140 pages. Price, \$4.95. New York: MacMillan Publishing Company, 1973.

Such is his reputation as a nephrologist that when Professor Hamburger addresses himself to other aspects of the human condition he deserves our careful attention. In *The Power and the Frailty* he has offered us his view as a physician and biologist of the revolutionary ferment brought to our daily lives by the accelerating application of new knowledge, a process which he sees as forcing on the physician a new role as diagnostician and therapist for the ills of a society unable to assimilate the offerings of modern science. Perhaps the most appealing part of his book is its title, illuminating as it does the contrast between the weakness of individuals and the limitless might possessed by nations which, whether as governments of the one or of the many, seem to be having increasing difficulty determining to whom their ultimate responsibility is due. Hamburger would have us, if I read him aright, accept his prescription that a redefinition of our scientific and humanistic aims and purposes followed by a reorientation in our actions, all designed to impress on man the need to be rational,

provides an adequate blueprint. To direct this new regime there must be developed a new managerial class enlightened in and by biology and beyond the profit motive as well. Yet this speaks for an elite, altruistic granted, almost supernaturally determined class, for how could self-selection create such a remarkable assembly? As the Watergate hearings, in recess as this is written, so trenchantly ask "who is to police the policemen?"

This is not to question Professor Hamburger's intense concern for man's future, else he could not exhibit such hope and faith, but to try to cast his assumptions in historical perspective. For when elites gain power they usually do so in league with the masses who hope for a better world and for a healing of their frailties. Yet true believers, as Eric Hoffer has so nicely argued, possess an almost infinite capacity for and acceptance of betrayal by the elite it has chosen as its leaders for those in office usually become enchanted by power and rendered helpless by strength.

What antidote can be offered to good intentions wedded to potentially totalitarian theories? Kind

words? Vigilance? Hardly. Rather should we as physicians exercise that same constructive skepticism which allows compassion for patients but prevents expectations greater than we or they can realize and maintain continued awareness that fixed stars fade and new trails usually appear when we most need them and have the greatest difficulty recognizing them.

If the medical reader really wishes to appreciate his place in this world of science he would be better

advised to read Alfred North Whitehead's *Science and the Modern World* which appeared in 1925, before the atom, before DNA and before Watergate and which provides a remarkable synthesis of what has gone before. For unless we know how our forbears coped with the crises of their day, as horrifying and overwhelming to them as ours to us, how can we improve our chances of recognizing and taking the right road today?

JOHN H. FELTS, M.D.

BASICS OF BIOAVAILABILITY AND DESCRIPTION OF UPJOHN SINGLE-DOSE STUDY DESIGN

This Upjohn booklet is concerned with the description of a certain application of bioavailability testing. The application discussed is that in which single-dose drug blood concentrations of two or more drug formulations of the same parent drug are compared. The authors wrote this booklet with the idea that there was a need for simplifying the principles and

applications of comparative bioavailability testing, and with special interest in bioequivalence testing. This is meant to be an introduction to the basics of bioavailability and might be of interest to our readers.

Included in this publication is a reference list of 297 articles relating to the comparative bioavailability of different drugs, as well as references to related review articles and editorials.

Copies are available upon request from The Upjohn Company, Kalamazoo, Michigan.

In Memoriam

George M. Bullard, M.D.

George Minson Bullard, M.D., was born in Roseboro, North Carolina on June 10, 1922, the son of a dentist. He attended public school in Roseboro and then entered the United States Army during World War II as a foot soldier. He was captured by the German Army in the Battle of the Bulge and held as a POW until the end of hostilities. His death occurred on June 7, 1973.

Following the war he graduated from Elon College and the Medical College of Virginia. He interned at Wilmington General Hospital.

He practiced medicine in Mebane, North Carolina for twenty years diligently and faithfully caring for a large practice. He was revered by his patients and respected by the medical community.

George Bullard used his compassion, loyalty, deep feeling and dedication to do his part in many basic programs and services in Alamance County. As a member of the Alamance County Board of Education, he gave much of his spare time in making a

valuable contribution to the progress of the Alamance County School System during a difficult transitional period. He served as a Trustee for Elon College with devotion and vigor. He was very active in affairs of his church, serving in many capacities. He was an accomplished organist who enjoyed and encouraged good music in the community, serving as a church organist and frequently participating in special music events. For many years he served as organist-director for the presentation of Handel's "Messiah," performed by the Mebane Community Choir.

George Bullard was a man of varied responsibilities and interests whose lifetime of contributions will long survive him.

ALAMANCE-CASWELL COUNTY MEDICAL SOCIETY

The name J. Street Brewer inadvertently appeared under "In Memoriam" in the Index to Volume 33.

NORTH CAROLINA

Medical Journal

SCHOOL OF MEDICINE
UNIVERSITY OF NORTH CAROLINA
CHAPEL HILL, NORTH CAROLINA

THIS ISSUE: State Mental Hospital Referrals: Patient Abandonment by Local Medical Resources, Keith R. Edwards, M.D., Gerald T. Gowitt, P.A., and Robert L. Rollins, Jr., M.D.; Folk Medicine in North Carolina, Leonidas Betts; Experience With a Skin Cancer Detection Clinic at a State Fair, Elizabeth P. Kanof, M.D.

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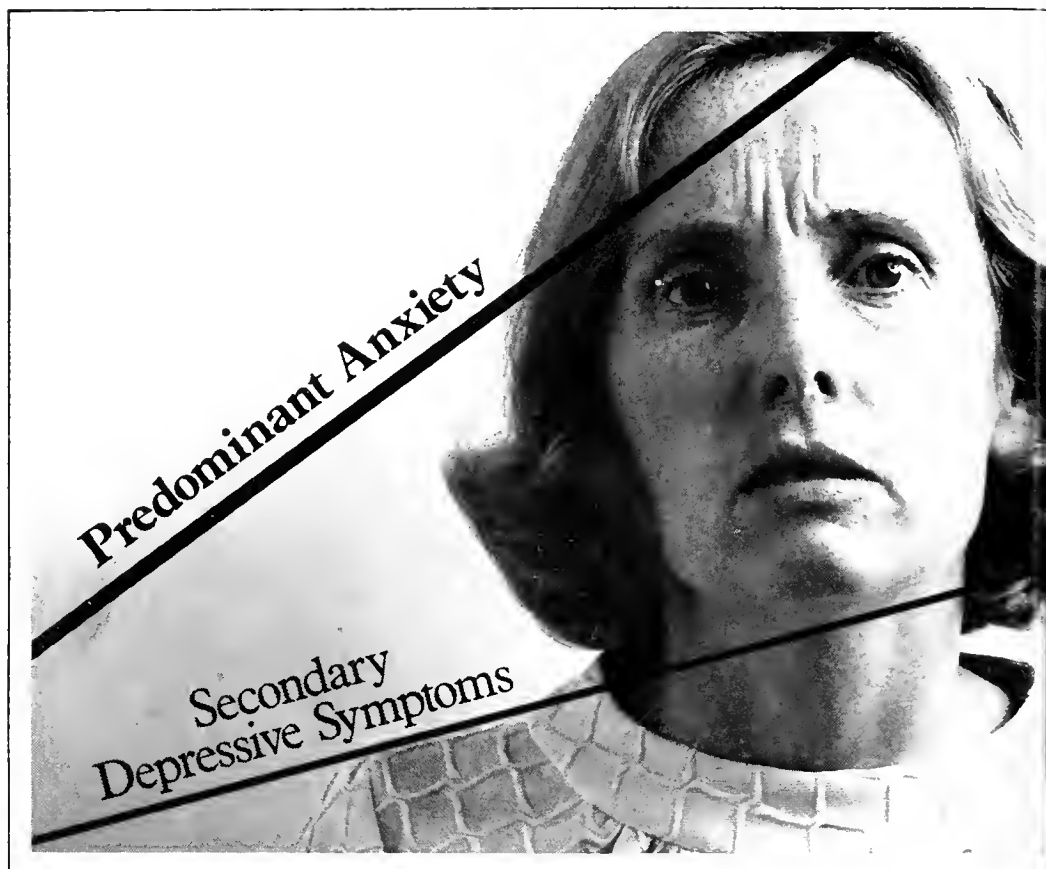


Additional information
available to the profession on request.

1974 ANNUAL SESSIONS
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Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant

medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

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PRESIDENT'S NEWSLETTER

MEDICAL SOCIETY OF THE STATE OF NORTH CAROLINA

No. 10

March 8, 1974

AMERICAN CANCER SOCIETY -- In general the vast amount of my time is spent in acting and reacting to bad news, controversies, the rotten apples in our barrel, and threats from all corners to our independence. It is therefore a refreshing pleasure to help publicize something wonderful and wholesome. One of the honors of my office is to be on the Board of Directors of the N. C. Division of the American Cancer Society. They are justifiably proud of one of their extremely valuable rehabilitation services. They are however disappointed that so few doctors know about these services or do not take advantage of them. Three post-operative groups of patient volunteers have been trained to help new victims of the same malignancies; namely (1) the postoperative laryngectomy patient, (2) the postoperative mastectomy patient, and (3) the postoperative patient with all kinds of "ostomies". These volunteers who have been through exactly the same crisis are trained to help meet the patient's physical, psychological, and cosmetic needs. By so doing, their service is invaluable to the referring doctor, not only in the physical training of the patients but by changing a depressed, ill adjusted patient into a hopeful useful individual. The whole point is that these services have to be initiated solely by the referring physician--you are the access to this vital program. There are six regularly scheduled laryngectomy speech classes spread about the state. The 216 "reach to recovery" postoperative mastectomy volunteers are available in 34 counties. There are 10 ostomy organizations distributed over the state. The availability of these services for your patients are as near as your telephone and local American Cancer Society office or the office in Raleigh whose phone number is area code 919-834-8463.

WAIVER OF LIABILITY -- Now to less appetizing news. Believe it or not the Prudential people who administer Part B of Medicare are really our friends and want to help us digest the nauseating regulations they have to administer. The case in point is yet another section of the old horror public law 92-603, Section 213. It provides for "waiver of patient liability on assigned claims for certain services and supplied denied as not covered". The explanation for this is summarized in a Medicare bulletin sent to you in January. If you didn't throw it away and can't understand it, join the club. The main point of this section of the law is that in certain complicated circumstances you may be left holding the bag for a Medicare Part B claim if you accept assignment. So, this is yet another crucial reason for not accepting assignment and our Prudential Part B carrier joins me in this recommendation.

CHEAPEST DRUGS -- If you follow medical news at all, you have heard that Secretary of HEW Weinberger has proposed that Medicare and Medicaid reimburse patients for only the lowest priced drugs unless the doctor can justify a higher priced one. This further manifestation of the climate in Washington has led to the following quote from an editorial in the February issue of the magazine "Private Practice". Can you imagine the time and effort it would take to justify all of a doctor's actions each day? It now appears that a doctor will have to justify why he saw a patient, why he got a laboratory test, why he made the diagnosis he did, why

he hospitalized the patient, why he kept the patient in the hospital for a certain number of days, why he performed surgery, why he chose a certain course of treatment--and now--why he prescribed each kind of drug. He must also justify his charges." This is as succinct a summary of our frustrations as I have read anywhere. The ethical drug firms and their representatives are really on the hot seat along with us.

COLC -- For those of you who did not read or have not seen the February 18th issue of the AMA News, you'll be happy to know that the AMA has gone to the District Court in Washington, D. C., with a suit against the Cost of Living Council for its maintenance of the health field under Phase IV. It is most heartening to have the AMA come out swinging in our behalf. This is where your pocketbook is involved and you may certainly site this action if you hear the query "What's the AMA Done for Me Lately?".

PROFESSIONAL INSURANCE -- As to what your State Society has been doing for you lately and has been doing as far as your pocketbook goes, recent experience with your professional insurance carriers leads to this very crucial and sound advice to help you stay out of court. To illustrate, an action against one of our members was recently thrown out of litigation on a basis of just one sentence written in the patient's office record. Hint: Make your office records (the average doctor does better with hospital records) intelligible and complete with pertinent details.

GASOLINE -- As of this writing, gasoline for doctors is in a state of confusion. It is hoped that by the time you read this, we may have already gotten equitable treatment for you at both the national and local level. Here again, the AMA has initiated strong pressure on Mr. Simon and we are doing likewise here in North Carolina but so far to no avail.

THE TAIL IS WAGGING THE DOG -- Required reading is in the February issue of the NORTH CAROLINA MEDICAL JOURNAL, the article written by Dr. Bernard Wansker, "The Tail is Wagging the Dog". This is the most concise and clear presentation of both definitions and delineations of the many complications of our third party intermediaries.

NEWSLETTER -- Many thanks to all of you who responded to the request in my last Newsletter as to its distribution. So far the opinions are about 10 to 1 in favor of enclosing it with the Public Relations Bulletin. This leads me to restate the standing invitation to comment on anything and everything else that we report.

Sincerely yours,



George G. Gilbert, M.D.
President

State Mental Hospital Referrals: Patient Abandonment by Local Medical Resources

Keith R. Edwards, M.D., Gerald T. Gowitt, P.A.,* and Robert L. Rollins, Jr., M.D.

THE medical profession is in an era of increasing awareness of patients' rights. Health care is often viewed as a right rather than a privilege. Consumers are asking elected representatives, as well as the medical profession, to increase availability of medical care to the indigent population.¹ Problems of medical ethics in relation to transplantation of organs, human experimentation, biomedical research, human fertilization, and the creation of life have appeared in the medical literature.²⁻⁷

In mental hospitals, patients' rights are increasing and practices of discrimination toward psychiatric patients are decreasing.^{8, 9} Discrimination by the medical profession against psychiatric patients who are outside of mental institutions has received little comment.

Psychiatric and alcoholic patients having multiple state hospital admissions often present special problems for the physician. Acutely psy-

chotic or inebriated patients may not give a reliable history. Their physical signs and symptoms may be overlooked, and commitment to a state mental hospital for treatment of an acute psychosis or "organic brain syndrome" may result from the patient's "label" as a "mental patient." Most referrals to a state hospital are appropriate and they primarily involve mental illness. However, any physician should first rule out an active organic disease process, especially in medically high risk patients such as those who have histories of mental illness or inebriation and who cannot, or will not, normally attend to physical problems. An alcoholic with a high fever or a middle-aged or elderly patient with an acute psychosis is usually medically ill; yet many such patients are sent to a state mental hospital — especially those who have histories of past state hospital admissions.

The following case reports are examples, not at all atypical, of the extreme degree to which a physician may overlook or neglect an impending or an active medical emergency, especially if the patient has been labeled because of a history of previous mental illness.

CASE REPORTS

Case 1

A 46-year-old man had a ten-year history of alcoholism and one previous uneventful admission to the state hospital inebriate ward. According to his wife, he had last been drinking heavily two weeks prior to admission. He had been in his usual state of health (inebriation) until one week prior to admission, when the onset of an upper respiratory infection and cough productive of a purulent sputum was noted. On the day of admission the patient became unconscious, without aura, and was taken to a local emergency room. The emergency room note records a blood pressure of 170/70. There is no record of other vital signs or of a physical examination. At the emergency room the patient apparently had a major motor seizure and was treated with diazepam and sodium bicarbonate, administered intravenously, in addition to oxygen. Postictally, appearing confused and delirious, he was given chlorthalidone, administered intramuscularly, and was referred to the inebriate ward for the treatment of alcoholism.

At this time, a physical examina-

*From the Department of Medicine, Boston City Hospital, Boston, Massachusetts (Dr. Edwards).
Physician's Assistant.
Superintendent and Director of Forensic Services, Dorothea Dix Hospital, Raleigh, North Carolina 27611.
Print requests to Dr. Rollins.

tion revealed severe respiratory distress in the obtunded, cyanotic male. His recorded blood pressure was 100/60, pulse rate 150 and regular, respirations 50, and his temperature 105 F rectally. Positive chest findings included diffuse wheezes, rhonchi, and rales most pronounced on the right side of the chest.

A cardiac examination showed a summation gallop and an aortic flow murmur. The abdomen was without bowel sounds, tenderness, or organomegaly. Clubbing and cyanosis of the extremities were present. Neurologic examination revealed obtundation and withdrawal response to deep pain and hypoaffective deep tendon reflexes; no pathologic reflexes were present.

The hematocrit reading was 42 percent, a white blood cell (WBC) count was 1,500. A repeat WBC was 600. A differential cell count, with only ten cells counted, showed four polymorphonuclear (PMN) cells, five bands and one metamyelocyte. The sodium was 114 mEq/L, potassium 2.5 mEq/L, and chloride 85 mEq/L. The PO_2 was 42 mmHg, PCO_2 was 24 mmHg, and pH was 7.50 while the patient received nasal oxygen. A chest X-ray showed pneumonia in the right lower lobe. Gram stain of the patient's sputum revealed many PMN cells, many gram positive diplococci, and some negative rods. Cultures of sputum, urine, blood, and cerebrospinal fluid were taken.

The patient was given gentamicin, penicillin, and cephalothin, injected intravenously, in addition to vitamins, folate, hydrocortisone succinate, a cooling blanket, nasotracheal suction, and postural drainage. Hypoxia was transiently improved in a 50 percent oxygen tent with elevation of PO_2 to 55 mmHg. The patient became progressively hypotensive and was poorly responsive to pressor agents. Subsequently, oxygenation deteriorated and he required ventilation on an Emerson respirator. The patient became anuric and died 26 hours after admission.

Post mortem cultures of sputum and blood revealed growth of *E. coli*

and *D. pneumoniae*. Autopsy revealed pneumonia of the middle and lower lobes of the right lung, bronchopneumonia of the middle and lower lobes of the right lung, and fibropurulent exudate of the right lung. Also revealed were moderate fatty changes of the liver and passive hyperemia of the kidneys.

Case 2

A 53-year-old man had been drinking one to two pints of bonded alcohol every day for the past thirty years. A history obtained from his wife indicated that he had been in good physical health until one month prior to admission when he noted the symptoms of progressive weakness, fever, and a cough productive of purulent, blood streaked sputum. Two weeks prior to admission the patient became too weak to work, and on the day of admission he was unable to rise from his bed. A local physician prescribed a medication and referred the patient to a local hospital.

At the local hospital the emergency room recorded a blood pressure of 100/60, pulse rate 100, respirations 26, and a temperature of 100.6 F. The lungs were described as clear. The patient was given 10 mg diazepam, administered intramuscularly, and having been given a diagnosis of "impending D.T.'s" he was referred to the mental health clinic. He was subsequently referred to the state hospital inebriate ward and was said to be suffering from acute and chronic alcoholism.

A physical examination on admission revealed a blood pressure of 120/60, pulse rate 150, respirations 40, and a temperature of 105 F rectally. The patient appeared to be markedly tachypneic and diaphoretic. The chest examination showed diffuse rales, most evident over the right mid-lung area. The liver was palpable 4 cm below the right costal margin. Lethargy, without focal signs, was noted on neurologic examination.

The initial hematocrit reading was 36 percent and a white cell count was 3,000. A differential cell count showed predominantly PMN cells

with a marked shift to the left. Blood chemistries were within normal limits except for a blood urea nitrogen (BUN) of 46 mg percent and a CO_2 of 15 mEq/L. A stool guaiac test was positive. A test for blood alcohol level was negative. Chest X-ray demonstrated a right, middle, and lower lobe infiltrate. Sputum gram stain showed many PMN cells, gram positive cocci in pairs, and gram negative rods.

After sputum, blood, and urine cultures were obtained, the patient was started on a medical program which included gentamicin, cephalothin, acetaminophen, SSKI, vitamin supplements, antacids, postural drainage, and an oxygen tent. In 10 percent headbag the initial PO_2 of 47 mmHg was raised to 66 mmHg. On the morning after admission the patient was confused. That afternoon he had a transient fall in blood pressure and respirations and a spontaneous return of all vital signs when he was in the supine position. On the evening of the second day in the hospital the patient had increased congestion over the right lung. Immediately after having been given nasotracheal suctioning, he had cardiovascular arrest and respiratory arrest; subsequent resuscitative attempts were unsuccessful.

Autopsy revealed extensive bilateral, acute pneumonitis. The total weight of the lungs was 3,150 gm. Post mortem blood and lung cultures yielded no growth. The liver was hyperemic with a diffuse pattern of finely nodular cirrhosis. The weight of the liver was 3,220 gm.

Case 3

An 80-year-old man had a longstanding history of episodic excessive drinking and three previous inebriate admissions to the state hospital inebriate ward. On the last admission four years ago, he was intoxicated with bromides, but he completely recovered.

A history obtained from his family indicated that the patient had not used alcohol or taken excessive medication for at least two years prior to his final hospital admission.

three days before the admission, symptoms of an upper respiratory infection and severe vomiting were noted. On the morning of admission the patient became confused and delirious. He was taken to a local emergency room where he was reported to be well oriented. The physical examination at the emergency room was unremarkable except for scattered rhonchi throughout the chest. The emergency room staff's impressions of the patient's condition were that he had bronchitis and possible alcoholism. No laboratory tests were ordered. The patient was given a prescription for tetracycline and he was referred to the men's health clinic. From there he was referred to the inebriate ward where he was given a tentative diagnosis of bromide intoxication.

The patient presented as a lethargic and confused elderly male. His blood pressure was 120/70, pulse rate 84 and regular, respirations 22, and temperature 97.6 F. The physical examination was unremarkable. The mental status examination showed markedly slowed thought processes and disorientation. A neurological examination showed only depressed deep tendon reflexes. Initially, a sodium was 110 mEq/L, potassium 4.0 mEq/L, chloride 76 mEq/L and CO₂ was 16 mEq/L. The urinalysis result was normal. Spot urine sodium was 0.0. Blood urea nitrogen (BUN) was 10 mg percent and a creatinine clearance was 1.15 mg percent. A test for bromide level was negative. Plasma cortisol levels were within normal limits.

The patient was given parenteral sodium chloride replacement which rapidly improved his mental status. According to psychiatric evaluation, the patient had mild senile dementia and was ready for discharge on the fourth day of his hospitalization.

4

A 64-year-old woman with adult-onset diabetes was reported by her treating physician to be without psychiatric problems and in good physical health until three months before admission. At that time she

had an acute myocardial infarction and was admitted to a local hospital. The course of her illness was complicated by pulmonary embolism and difficulty in diabetic control. The patient became confused and disoriented, showing inappropriate behavior which persisted after the acute episode. She was treated with a regimen of digoxin 0.25 mg daily, 20 units NPH insulin each morning, and chlorpromazine as needed.

Eleven days prior to admission the patient was again sent to a local hospital because of complaints of dyspnea and anxiety. Bradycardia and bigeminal rhythm were noted on admission. In the hospital, several electrocardiograms (ECG) demonstrated a junctional rhythm and a steadily declining cardiac rate. The patient was treated with atropine and meperidine administered intramuscularly, as well as nasal oxygen. Her mental status continued to deteriorate and she was referred to the state hospital psychiatric ward with a tentative diagnosis of chronic undifferentiated schizophrenia.

Her blood pressure on admission was 98/50, temperature 99.4 F, respirations 16, and pulse rate 44 and irregular. The patient, confused and disoriented, was unable to give a history. The fundi showed microaneurysms and hard exudates. The neck veins were distended to the mandibular angle at 30 degrees. There was a soft bruit over the right carotid artery. The chest examination showed moist rales in the left base, but was otherwise clear. Cardiac examination revealed an irregular rhythm without murmurs or gallops. There was no peripheral edema. The abdominal examination was unremarkable. No focal neurologic signs were present.

Laboratory studies included a hematocrit reading of 30 percent and a WBC count of 6,900 with a normal differential. Blood chemistries were within normal limits, with the exception of a glucose of 130 mg percent and a BUN of 42 mg percent. Urinalysis showed 1+ protein and 50 to 60 WBC per high powered field. Chest X-ray showed cardiomegaly and pulmonary con-

gestion. The serum digitalis level was 0.4 ng/ml. ECG showed an irregular junctional rhythm with frequent premature ventricular depolarizations and periods of bigeminy at a rate of 42 to 48. There was evidence that the patient had had an anterior myocardial infarction at an undetermined age.

The patient was transferred to the intensive care unit and placed on a cardiac monitor. Atropine, administered intravenously, produced no change in cardiac rhythm. Because pacemaker facilities were not available at the state institution, the patient was transferred to a nearby hospital where a transvenous pacemaker was inserted. She developed intractable heart failure and died 72 hours after transfer.

Case 5

A 39-year-old man had been admitted, three years ago, to the state hospital inebriate ward where he underwent uneventful detoxification from alcohol. Three months prior to his final admission he began drinking one to two pints of bonded alcohol each day. However, he claimed to be in his usual state of good health until two days before admission when he noted the onset of severe, penetrating, midepigastriac pain which persisted without relief. Besides bilious and bloody vomiting, the patient had melena, a cough productive of purulent sputum, pleuritic chest pain, and fever.

He was taken to a local hospital by his regional alcoholism counselor who described him as being in "too much pain to walk." The emergency room made no record of the patient's complaints, although they described him as smelling strongly of alcohol. However, the patient, the alcoholism counselor, and the family denied that the patient had consumed any alcohol for 48 hours prior to the time he was admitted to the local hospital. Vital signs noted a blood pressure of 130/100 and a rectal temperature of 96 F. The result of the chest examination was normal and the abdominal examination records note only an enlarged liver. The patient was given 75 mg

chlordiazepoxide, administered intramuscularly, and he was referred to our inebriate ward for the treatment of acute and chronic alcoholism.

Physical examination on admission showed a diaphoretic male with intense abdominal pain. A blood pressure was 120/90, temperature 100.4 F, pulse rate 136, and respirations 24. The abdomen was rigid and exquisitely tender with rebound present. Bowel sounds were diminished. The size of the liver was normal. There was no costovertebral angle or back tenderness. The initial diagnosis was acute pancreatitis.

Laboratory data included a hematocrit reading of 36 percent and a WBC count of 9,300 with a slight shift to the left. Blood glucose was 225 mg percent and BUN was 29 mg percent. Calcium was 7.0 mg percent and phosphorus 2.2 mg percent. Glutamic oxalacetic transaminase (SGOT) was 192 mg percent and amylase 432 mg percent. Chest X-ray was normal. Abdominal flat plate demonstrated an ileus. The sputum was "Quellung positive."

After blood, sputum, and urine cultures were obtained, a medical program of intravenous fluids, cephalothin, diazepam, meperidine, acetaminophen suppositories, and frequent nasogastric suction was administered to the patient. Oral chlore cystogram was normal. The patient had an uncomplicated course and recovery, with amylase returning to normal after nine days of his hospitalization.

Case 6

A 52-year-old black man, having a twenty-year history of hypertension and cigarette smoking, was healthy until 1969 when he had a cerebrovascular accident with resulting left hemiparesis. The patient began having seizures with a right cerebral focus several months later. His seizures were controlled with phenobarbital and diphenylhydantoin. The patient had one previous state hospital admission in April of 1970 for transient confusion secondary to "organic brain syndrome." He lived

at home and functioned in the care of his wife until the day prior to admission when he became confused, combative, and aphasic. He was taken to a local emergency room. His wife was told that the patient had a "near stroke," and he was sent home. Later the same evening, the patient returned to the emergency room with aphasia and increasing confusion and combativeness. He was referred to the state hospital with "possible psychosis" as the only diagnosis on the commitment papers. No record of a physical examination or laboratory data was available.

On admission to the state hospital, the patient's confusion and aphasia were resolved. The patient appeared oriented and cooperative, his chief complaint being of recent inability to talk, weakness in the left side, and mild chest pain. The pulse was irregular. An electrocardiogram demonstrated acute anterior myocardial infarction, frequent multifocal premature ventricular depolarizations, and periods of bigeminy. The patient was transferred to the intensive care unit where he received lidocaine intravenously, procainamide orally, oxygen, and later, digoxin and diuretics for congestive heart failure. Neurological examination revealed sensory and motor deficit and hyperreflexia on the left side. An electroencephalogram showed random slowing. Electrocardiogram and serum enzyme changes after the acute episode confirmed the diagnosis of an anterior myocardial infarction. It was thought that the patient's aphasia and confusion were caused by a transient cerebral ischemic attack. Lipid panel showed a type IV hyperlipoproteinemia.

The patient had a successful convalescence without further complications. He was oriented and cooperative and showed no evidence of psychosis during his entire hospitalization.

DISCUSSION

These six patients, referred from emergency rooms or from physicians' offices, were sent to the state

hospital with no record of complicated diagnostic problems or occult diseases. Yet each of these patients had a life-threatening disease in its acute phase.

Case reports 1 and 2 were reports of patients who died during the first day after admission to the psychiatric hospital. One may only speculate whether the delay in treatment after the transfer from an emergency room, commitment proceedings, and re-evaluation after admission would have made any difference in the final course of the disease. However, the issue is whether a non-former psychiatric patient would have received the same treatment as a patient having a history of psychiatric treatment.

Case report 3 concerns an 80-year-old man who was sent from an emergency room to the state hospital without having had a complete physical examination or laboratory studies done. His diagnosis of late-onset sodium psychosis was made, after admission, from the minimal routine laboratory studies.

Case report 4 concerns a 64-year-old woman having a three-month history of confusion which began acutely after a myocardial infarction. The patient had no previous history of mental illness. Having had no neurological studies done, the patient was referred to the state hospital with a single handwritten note from the physician stating that she had schizophrenia. On admission the patient was found to have an irregular bradycardia and a low blood pressure. Her "mental condition" was probably the result of a cerebrovascular accident of cardiogenic origin. She was hardly a candidate for a psychiatric hospital.

In case report 5, the patient had a high fever and peritoneal signs and was referred from an emergency room. The referring diagnosis at subsequent commitment presumably had been based solely on the problem of alcoholism. The physical examination and serum amylase levels confirmed the diagnosis of acute pancreatitis.

Case report 6 concerns a patient who had a clear history of acute

phasia and confusion. One cannot know whether the patient's irregular pulse and chest pain were as prominent in the emergency room as they are on admission to the state hospital, but an acute cerebral ischemic attack is usually not considered to be a primary psychiatric problem.

The five most common physical disorders associated with alcoholism—delirium tremens, "blackouts" and convulsions, liver damage, peripheral neuritis, and stomach disorders. The alcoholic patients who are presented here had fewer commonly occurring disorders. That more significant disease might have been present should have been questioned. Chronic alcoholics often do not give reliable histories and they are not noted to be cooperative patients. However, the physician must examine himself, as well as the patient, in reference to his attitudes toward the patient. When the physician has failed to communicate with the patient, he often describes the patient as being "uncooperative" or "unreliable." Regarded as such, the patient sometimes is sent as quickly as possible to the state hospital, regardless of concomitant physical disease.

These cases are not presented to criticize the medical care provided in any particular region, nor to criticize any group for practicing inferior medicine. The referrals discussed here are from a too divergent, otherwise competent, group of hospitals and physicians to suggest that these physicians are incompetent. These cases present the effects of a basic discriminatory attitude toward patients who have psychiatric or alcoholic diseases. One patient aptly expressed the following attitude: "See you're a (state mental hospital) patient, you're branded." Another stated, "Once a psych patient,

always a psych patient. That's how they (physicians) feel about you."

There are several ways to limit these inappropriate, end-of-the-line physician referrals for patients who are abandoned by their appropriate local medical resources. One approach for the improvement of health care for "undesirable" potential or for former mental hospital patients is to restrict mental hospitalization policies. The current debate on voluntary mental hospitalization has been reviewed recently.^{12, 13} The status of involuntary hospitalization for people having mental illness has been questioned and suggested revisions have been proposed which include shortened observation periods in the commitment process, expansion of patients' civil liberties and right-to-treatment, a legal aide system for mental patients, and a patient advocate program.¹⁴ Both voluntary and involuntary hospitalization is subject to indiscriminate application. It is apparent that former hospital patients, particularly those with past inebriate admissions, are sometimes given a choice between jail and voluntary commitment.

Significant revisions of mental hospitalization laws are needed before abuse of patients' rights to proper physical and mental care can be corrected.

SUMMARY

The medical profession is becoming increasingly aware of patients' rights, particularly in the field of mental health. This report has included an account of six patients, having a primary referring diagnosis of mental illness, who were transferred by various physicians to state mental hospitals. On admission to the state hospital each patient had a life-threatening physical condition

which required intensive medical care. It is our contention that inappropriate referrals to state mental hospitals are sometimes made when patients are confused or when they present a management problem, even if overwhelming physical disease is the cause of their mental status changes. Those patients having histories of state hospital admissions are at risk to be disregarded by their local medical resources and to be sent to a state mental hospital, regardless of concomitant physical illness. They have been "labeled" by their past histories of hospitalization in mental institutions. Disposition may reflect this label rather than an objective review of the presenting symptoms.

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Where cold bathing is practiced, there ought likewise to be tepid baths for (gradual transition). Indeed, it is the practice of some countries to throw cold water over the patient as soon as he comes out of the warm bath; but though this may not injure a Russian peasant, we dare not recommend it to the inhabitants of this country. The ancient Greeks and Romans, we are told, when covered with sweat and dust, used to plunge into rivers, without receiving the smallest injury. They might often escape danger from this imprudent conduct, yet it was certainly contrary to sound reason.—*William Buchan: Domestic Medicine, or a Treatise on the Prevention and Cure of Diseases by Regimen and Simple Medicines, etc., Richard Folwell, 1799, p. 428.*

Folk Medicine in North Carolina

Leonidas Betts*

WHILE I was studying at Duke, I made the acquaintance of a student, the son of a prominent Charlotte surgeon, who arranged his dormitory-room furniture in an unorthodox manner. Since I am inately curious about almost everything, I persisted in my inquiries about the position of his bed. Worn down at last, he finally gave me an answer which was at first shy but became defensive in the telling. "It has to do with health," he said. "Health? Are you trying to keep from sleeping in a draft?" I pursued. "Hell, no! Don't you know you'll go crazy if you sleep in moonlight?" he said. I laughed until I realized how serious he was. The old ideas persisting—"lunaacy," "moon-madness." And he was a physician's son. I inquired no more.

In the early days of its study, folklore was viewed as the "remains" of past culture, curious relics, beliefs, and practices surviving from days gone by. The modern folklorist, however, sees folklore as an on-going body, its content dying gradually at one end and growing at the other. Today folklore is defined as the materials of any culture that are transmitted by oral means or by example, that are traditional within any group,

that are generally anonymous, and that become formularized. Thus, by definition, everyone has folklore. The old mountain woman singing a "ballet" on the front porch of her log cabin is no more unique a source of folklore than the urban housewife or the insurance executive or the physician. Every socialized individual belongs to several groups distinguished by age, occupation, ethnicity, region, and various combinations of these; and he shares with his groups the baggage of their traditional lore.

The study of folklore has three phases: collection, classification, and analysis. Collection, understandably, has been the most successful of these. Vast quantities of materials have been gathered throughout the United States. Without doubt, the finest state accumulation is the *Frank C. Brown Collection of North Carolina Folklore*, running to seven thick volumes, published by Duke University Press. Classification, too, has made significant progress, and standardized procedures have been developed to enable the collector to arrange his findings into some formalized pattern for the purposes of comparison and cross-reference. However, analysis is still in its infancy, with psychiatrists, sociologists, anthropologists, and English professors vying for supremacy. Increasingly, folklorists are

attempting to view folklore in so as part and parcel of a societal process.

My keenest interest in folklore study is in the area of superstition, or, euphemistically, "popular beliefs." Two volumes of the *Brown Collection* are devoted to the subject, with a total of more than 8,000 entries. In addition, Professor Joseph D. Clark has published some 2,000 items in the journal *North Carolina Folklore*.¹

Superstitions do not readily yield to education. Studies over the years have shown no decrease in their prevalence. In 1950 an Indiana anthropologist, with college students as subjects, made a study of superstitions using highly sophisticated statistical methods. He discovered that students are as superstitious as they ever were, that women are more superstitious than men, and that, most intriguing, the more educated the parents, the more superstitious the children. Further, urban students proved to be as superstitious as those from rural areas. There are folklorists who claim that every individual harbors some kind of superstitious belief within himself.²

If we look at medical practices and their relation to superstition or popular belief, we find a curious and complex situation. Scientific medicine and folk medicine exist side by side, each contributing to the es-

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nance of the other, often in tension, occasionally in harmony, the *materia medica* of one sporadically passing to the other in a kind of begrudging comradeship. What passes out of favor in legitimate medicine may find its way into the repertoire of the folk healer. Physicians in the nineteenth century held firmly to the "doctrine of signatures" which proposed that the colors and forms of herbs signified their usefulness in treating diseases or affected anatomical features with similar colors and forms. In folk medicine the doctrine ultimately accreted application of mineral elements. That red beads worn about the neck prevent nosebleeds is a belief recorded in North Carolina and in other areas throughout the United States.³

On the other hand, folk cures can readily pass into recognized medical practice. An issue of *The News and Observer*⁴ carried a United Press International release concerning a report to the American College of Surgeons, by Dr. Paul Everstein of the Army Institute of Surgical Research, that pigskin is as effective as cadaver skin in the treatment of burns. (I must admit to some ignorance here: application of clover skin sounds like something from dark times, when moss from a hanged man's skull was valued as a potent curative.) In any case, for countless years the application of fish hog meat has been a standard treatment for burns among the countryside folk. And now, at last, its discovery by science! These days are beset with media releases about acupuncture. And, according to a *Time*⁵ magazine report, faith healing is being seriously studied by medical researchers.

Folk cures are generally divided into two, sometimes ill-defined, varieties: the magicoreligious and the rational or herbal type. My experiences with the faith healing, especially magicoreligious variety are limited.

However, many common folk cures have strong elements of the magicoreligious in them. For example, I have met a number of people who firmly believe that

bleeding can be stopped by repeating applications of Ezekial 16:6 three times. And one of my best informants told me of a foolproof preventive for whooping cough, a procedure with absolutely no rational basis: "Take a live minnow and let him gape in a baby's mouth three times, and the baby won't have whooping cough."

Most folk cures consist of concoctions of roots, bark, leaves, natural minerals, and purchased chemicals which seem, on the surface, to be posited on some systematic, reality oriented worldview, although these too may contain some element of irrationality. One informant showed me a pine grove on her farm that had provided her for many years with both purgatives and cures for diarrhea. The inner bark of the tree works both ways, she explained: "If you cut up, that white bark'll clog up loose bowels, but if you cut down, it's a mighty potent laxative. I used it both ways on all my children whiles they were growin' up."

Under the heading "Folk Medicine," the *Brown Collection*⁶ alone contains 2,290 items gathered from North Carolina sources. The preponderance of these were assembled during the period 1910-1940, and a look at them can reveal something about what the canon of folk medicine has been at some point in time past. Obviously, many folk remedies have passed away, even in memory, as new folklore is created. My field studies seem to indicate a continuous deterioration of old-time folk medicine from generation to generation. Even the elderly many times remember folk cures but they no longer use them.

It is interesting to examine some of the *Brown* entries, not only as a revelation of a view of the nature of things significantly different from our own, but as a source of amusement. The following is a sampling of some of the more picturesque beliefs in the collection:

If you take a pound of shot and boil it in water for several hours, and then drink two swallows of the water, you will be cured of boils and never be troubled with them again. (956)

For chapped lips, kiss the middle rail

of a five-railed fence. (1017)

'When younguns have got chicken pox you lay 'em down on the floor and shoos the chickens out over 'em. Hit'll break 'em out in two hours. Why the day the baby got 'em I se'd the fust bump comin' and I shoody the old Dominnecker over her and she was all pimpled out in a hour.' (1019)

If a child has chicken pox, grease him with chicken grease, and put him naked in the chicken house. (1021)

For severe constipation, cook a package of fine-cut tobacco in a quart of boiling water and strain. Use a pint as an enema, and if necessary repeat with a second pint. This may slightly inebriate the patient, but the effect will soon pass. (1185)

Pour whiskey on roaches to stop convulsions. (1197)

There is a bone in the penis of the raccoon similar in shape to the letter 'J.' The old 'coon hunters of the neighborhood used to tell the younger set that if this bone should be worn about the neck or carried in the pocket, the carrier would never have cramp. (1231)

Bite off the dog's tail to prevent infection from dog bite. (1292)

To cure headache, take a live frog and bind it to your head, and let it stay there till it dies. (1584)

If you have the hiccoughs, think of a fox with no tail. (1633)

For yellow jaundice, catch nine lice off someone's head and eat them. (1756)

For rheumatism, fill a can with angleworms, let it stand in the sun all day, and rub the oil in the stiff joints. (1697)⁷

My field collecting has yielded a number of folk remedies not found in *Brown* nor in Clark's items. My best informant, Mrs. Hattie Holt, a country woman in her seventies, swears by snow water for the treatment of burns: "Gather up snow from the first snowfall in March, melt it and put it in glass jars for the rest of the year. There's an acid in it that'll take out fire. I don't know why you have to have March snow, but other kinds of snow won't work." (She was gracious enough to give me a jar of the miraculous water, which I am saving for future use). About croup, she told me, "It don't sound reasonable, but it does work, 'cause I've tried it lots of times. Stand the croupy younguns out in the yard, no matter if there's snow on the ground. It'll cure croup, for sure." And Mrs. Holt has told me on good authority that standing barefoot on the ground will cure "nerves." "I do it all the time," she said. (Psychiatrists, take note.) For teething babies, she observed, "I know this 'un to be so. Kill a rabbit and get his brains out hot. Rub it on

the baby's gums. It'll help. I don't ever do it, but I knowed them that did do it."

One striking characteristic of folk medicine that becomes readily apparent to the collector is that frequently the more nauseating the remedy, the more effective its powers. Pity the poor child with measles. Teas brewed from chicken manure, goat dung, rabbit "pills," or sheep sorrel were (and may still be) prescribed. One of my informants stated, without qualification, that the best cure for toothache is a poultice of warm cow manure placed on—of all spots—the elbow. The ubiquitous and vile-smelling asafetida is still around. As you probably know, asafetida is generally worn in a small cloth bag around the neck as a method of warding off colds and sundry disorders. However, its makers list it as a carminative and a placebo. (I wonder what asafetida-wearers think those terms mean.) On one occasion an informant remarked to me, "Sometimes I think younguns got well so they wouldn't have to be dosed with some of these cures." Maybe so.

There are folk terms for disorders, although most conditions remain unlabeled and are simply described by symptoms. Disease names include "golly marbus," "mully grubs," "humors in the blood," "spring disease," "high-galloping poots," "serofus," and "courage bumps." Many are corruptions of current medical terminology: "roaches of the liver," "phosphate gland trouble," and "sinus of the stomach," as well as one case of "double pneumonia of the lungs and kidneys."⁹ An informant related to me that she had been to the hospital to get "bluecoats" put in her blood. And another told me that a certain home remedy was "good for children as well as adulterers."

In the course of my investigation, carried on primarily in rural eastern North Carolina, I have sat in the parlors of fine country houses, on land continuously in family possession since the eighteenth century—my informants articulate, well-travelled, and educated; and I have

perched precariously on plank-bottom chairs in hovels of unimaginable squalor, expecting at any moment an attack from some awesome kind of vermin, while I collected bits and pieces of the unwritten traditions of the past and the present. All levels of society have yielded their lore.

But as I stated previously, most traditional folk medicine in the countryside exists more in memory than in usage. When I am told of the effectiveness of a certain remedy, often told with a personal testimonial, I inquire about its present day use. The answers I receive are generally apologetic: "You can't get pussley no more. It's stopped growin' 'round here"; "Since the younguns have growed up, I don't have no need for these old cures." "I'm taking some pills the doctor gave me. They work pretty good." "I go to the drugstore and get store-boughten medicine."

Even so, a few folk remedies persist; but more and more, they are yielding to increasing medical availability and perhaps, in some cases, to the promises made by the advertising media. Why use ginseng to promote sexual potency, when there is Ultra-Brite which gives one sex appeal? Why stand barefoot on the ground when one feels nervous, when there is Compoz? Why make the children drink rusty water to put iron in their blood, when there are Chewable Chocks for Kids? Why use Virginia creeper tea for constipation, when there are scores of prepared laxatives, including a particular brand which improves one's attitude toward incorrigible grandchildren and which cleanses the bowels as well?

In spite of whatever advances medical science will make, an element of society will first try a home remedy, then go to the drugstore for a patent medicine, and finally consult a physician, if all else fails.

There are parallels. One morning as I sat in my internist's examining room, enduring one of those interminable periods of waiting and feeling depressed and helpless, as I always feel in a doctor's office, I

became rather desperate to find something to take my mind off what I was convinced was a terminal illness. I spied a paper entitled "Treatment of Warts"¹⁰ under the glass top of an equipment case. Not having had warts, I was nonetheless curious about their treatment, just in case I ever developed one, if I survived my illness. The paper described the procedure in three parts. First came "The Therapy of Inspiration," which included this suggestion: "Flat warts or digitol [sic] warts that are not spreading, paint with mercurochrome or other organic materials. . . or other color hocus pocus and apply it with vigorous personality." Second came "The Therapy of Desperation," with six seemingly scientific possibilities. The list ended with "The Therapy of Panic": "Refer the patient to dermatologist." With an embarrassed laugh, I knew that my terminal illness had miraculously disappeared.

One last example of folk-healing (The best informants readily give testimonials about the efficacy of their methods.) One old lady told me her pokeberry "wine" was a fail-proof cure for arthritis. "I knew a woman," she related, "that was crutches. I took her some of my pokeberry wine, and the next time I seen her, she 'us totin' water to the chickens, two buckets at the time." Her recipe was as follows: Take a gallon jar and fill it with ripe pokeberries. Then pour whiskey into the jar right up to the top. Drink it if needed. O happy arthritic. . . .

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Experience With a Skin Cancer Detection Clinic at a State Fair

Elizabeth P. Kanof, M.D.

KIN cancer detection clinics are not new. Weary¹ reported his experience with a number of annual clinics in a rural community in Virginia. These clinics were held on Saturdays. The best attendance was recorded in the spring or fall when the clinics were held in conjunction with events which brought farmers to town. Adequate publicity via the news media was extremely helpful in attracting community residents.

Patients who presented themselves for examination in the study mentioned were not restricted as to age. They were routinely screened for lesions in the oral cavity and on light-exposed areas of the body (from the clavicle up, and from the elbows down). Examination of other areas was included only upon the patient's request. Of 548 patients examined, 118 had been referred for treatment. Approximately ten patients were examined per hour, per physician. The gratifying results of the clinics yielded an overall detection rate of 21.6 percent premalignant or malignant lesions in the population examined.

In Weary's study, patients in whom significant malignant or premalignant lesions were found received adequate follow-up care. Their private physicians were notified by mail. Subsequently, a volunteer from the American Cancer Society, after conferring with the physician regarding his preference for disposition of the problem, encouraged the patient to follow through with treatment. It was stressed beforehand that, although the clinic was free, the patient would be responsible for the fee to the physician who undertook treatment. No difficulty was encountered in securing dermatologists to volunteer their time to the clinic.

Approximately 50 percent of all patients screened in these clinics received information regarding adequate sunlight protection. It was learned that the vast majority of people examined did not wear hats or sunscreens during the summer months. An instruction sheet of appropriate measures, such as using umbrellas while operating tractors, and a list of appropriate sunscreens were distributed to these patients.

The cost of the screening clinic was minimal—\$23.26 per clinic, including the cost of all promotional activities.

It is not surprising that the yield of significant lesions in a skin cancer detection clinic was higher in Virginia than in New York City.² As noted by A. Kopf, M.D. (written communication, 1972), during a Cancer Detection Week held in November 1971, sponsored jointly by New York University Medical Center, Bellevue Hospital and the New York City Division of the American Cancer Society, 643 patients were examined. Four of these patients (0.62 percent) had malignant skin lesions, and 15 (2.33 percent) had possible malignant lesions.

In October, 1972, the National Program for Dermatology, in cooperation with the North Carolina State Board of Health, the American Cancer Society, and the North Carolina Medical Society, undertook a similar project at the North Carolina State Fair. The main objective was educational: to increase the public's awareness of the relationship between excessive sunlight exposure and skin cancer.^{3, 4} The detection of significant lesions was used to emphasize this educational effort. Six hundred thousand people visited the Fair during a ten day period. The booth was open seven hours daily, for nine days. During those nine days, 11,750 people studied the posters, and they were

¹Presented at the Annual Session, North Carolina Medical Society, Pinehurst, North Carolina, May 20, 1973.
²Print requests to 1300 St. Mary's Street, Raleigh, N. C. 27605.

given booklets about skin cancer,^{5, 6} as well as a sample bottle of a medically accepted topical sunscreen.

Each of the nine sessions, with one attending dermatologist per session, lasted three and one-half hours. Three auxiliary volunteers (per examination session) were provided by the North Carolina State Board of Health and the Auxiliary of the Wake County Medical Society. During the hours when a physician was not present, at least one volunteer was in attendance to distribute pamphlets and samples and to answer questions. A total of nine dermatologists took part in the clinic.

The educational posters and the booth occupied an area of 200 square feet, divided as follows: a reception area in which volunteers assisted people with the questionnaire form (Figure 1); an examination area divided into two sections by a partition; and an exit area where a volunteer, after distributing booklets and sunscreen samples to patients following their examinations, discussed with the patients their decision regarding treatment. Those patients from remote areas, or who were obviously indigent, were referred to their county health department.

In this study, the patient was given the ultimate responsibility for confirmatory biopsy and subsequent treatment. The physicians in the state were alerted beforehand via the secretaries of all county medical societies, and by the society news bulletin. Because a large number of people from widely different geographic areas of the state were seen, the individuals' family physicians were not notified in writing (Table 1).

During the nine sessions, 418

people, 21 years of age or older, were examined, averaging 46 patients per session. Lesions of such significance as to warrant referral were found in 158 (37.8 percent) people. Patients having significant oral lesions were referred to an oral cancer detection clinic being held simultaneously. On the light-exposed areas (face, neck, chest, back, and upper extremities), the most frequent lesions found in the 158 persons referred for treatment were solar keratosis (19.6 percent), basal cell carcinoma (3.6 percent), and nevus with questionable malignant change (3.3 percent). A variety of other malignant and premalignant lesions were also detected (Table 2).

Informality was helpful in encouraging participation. The number of people waiting for examination significantly increased when

Table 2
Summary of Experience

	Number	Percent
Patients not referred	260	61.2
Patients referred	158	37.8
Multiple actinic keratosis	82	19.6
Basal cell carcinoma	16	3.6
Suspicious nevi	14	3.3
Squamous cell carcinoma	5	1.1
Melanotic freckle	3	0.6
Multicentric superficial		
BCE vs. Bowen's	3	0.6
Leukoplakia	2	0.4
Malignant melanoma	1	0.2
Cutaneous horn	1	0.2
Recurrence BCE or Bowen's	1	0.2
Pigmented BCE vs. Melanoma	1	0.2
Miscellaneous	53	12.4
Total number of patients examined	418	100

SKIN CANCER DETECTION CLINIC REGISTRATION FORM

Please fill in Sections I, II, and III

SECTION I

Date: _____

Name _____ Age _____ White _____ Non-White _____ Sex _____

Address _____ Telephone _____

Occupation _____ Number of Years _____

SECTION II

Estimated average daily time spent outdoors, May - September? _____ Hours

History of skin cancer? Yes _____ No _____

History of skin cancer in other members of family? Father _____ Mother _____ Siblings _____

History of X-Ray treatment for acne or other skin conditions? Yes _____ No _____

Do you use arsenic-containing insecticides or spray? Yes _____ No _____

Do you regularly come in contact with tar or creosote? Yes _____ No _____

Color of hair (original color)? Blond _____ Red _____ Brown _____ Black _____

Color of eyes? Blue _____ Green _____ Brown _____ Other _____

Complexion -- Freckled _____ Ruddy _____ Dark _____ Pale _____

Do you regularly wear a hat with a brim in summer? Yes _____ No _____ In winter _____

Do you regularly use a sun screening preparation? Yes _____ No _____

SECTION III

Have moles rapidly enlarged or darkened recently? Yes _____ No _____

Are there any places on your skin which are sore and will not heal? Yes _____ No _____

Do you have any sore or irritated places in the mouth? Yes _____ No _____

Do you smoke cigarettes? Yes _____ No _____

Do you smoke a pipe? Yes _____ No _____

Do you smoke cigars? Yes _____ No _____

Do you chew tobacco? Yes _____ No _____

Do you wear dentures? Yes _____ No _____

Additional pertinent historical facts _____

SECTION IV

Examination:	Refer	Not Refer
Face		
Ears		
Mouth		
Neck		
Palms		
Dorsum of hands and forearms		
Trunk or other sites if indicated		

SECTION V

Follow-up: 1. Refer to family doctor _____ or dentist _____

2. Refer to other doctor _____ or dentist _____

3. Refer to health department _____

4. Other: _____

State Fair Exhibit
National Program for Dermatology - N. C. Division, American Cancer Society
N. C. State Board of Health
1972

Table 1

Geographic Distribution of Persons Examined

Residents of North Carolina	Percent
Western Section	3.7
Piedmont Section	74.3
Eastern Section	18.3
Out of State	3.7

Fig. 1

white coats were shed, when the physician appeared in the reception area from time to time evidently enjoying himself, and when volunteers assured those who were hesitant that no procedures were entailed.

The response of the news media is gratifying. All major newspapers, television, and radio networks covered the event. Personal interviews with participating physicians were held prior to the sessions and while the booth was in progress.

The major expense of \$200 for the booth rental was covered by the American Cancer Society. The design and erection of the booth, printing of the patient questionnaire forms, and the notification of the county medical societies were handled by the North Carolina State Board of Health.

Several problems were encountered during the study. Some confusion arose regarding the division of responsibilities among the large number of volunteers. In order to more effectively answer patients' questions, volunteers should have been more adequately briefed by the dermatologists. The examining areas were makeshift, providing inadequate light and ventilation, and no plumbing.

After the Fair ended, a questionnaire was sent to all physician volun-

teers requesting their anonymous, frank appraisal of the project. All expressed the opinion that the project was worthwhile. According to Robert Gilgore, M.D. and Mrs. Gertrude Price (written communications, 1972), two physicians volunteered to conduct similar clinics in other counties and they submitted plans to the National Program for Dermatology in the hope of coordinating efforts.

The public openly expressed their appreciation for the efforts of all people involved in the project. Young adults appeared to be impressed with the information at hand, and many indicated their awareness, for the first time, that skin problems in the future could be minimized or avoided. Colleagues in other fields expressed their interest and support. And, we enjoyed the strengthening of friendships and closer professional ties, as well as the gratification derived from a job well done.

SUMMARY

Nine skin cancer detection clinics were held at the 1972 North Carolina State Fair. The primary objective was educational; i.e., to increase the public's awareness of the relationship between excessive sunlight exposure and skin cancer.

Eleven thousand seven hundred people received educational material. The light-exposed areas of 418 patients were examined; 37.8 percent of this group were referred for further diagnostic work and treatment.

Acknowledgments

The author wishes to acknowledge the assistance of the following people: Mrs. Harriet Flint, Program Director, North Carolina Division of the American Cancer Society and Miss Grace H. Daniel, Chief, Health Education Section; Mrs. Jane Gauntz, Artist-Illustrator, Dental Health Division, and Dr. Isa Grant, Chief, Chronic Disease Section of the North Carolina State Board of Health.

Appreciation is expressed to the physicians participating: Drs. Edward Burton, Robert Gilgore, Frank Houston, Mendel Jordan, W. Stacy Miller, Frances Pascher, Wade G. Rhoades, and Harry Scott.

Appreciation is also expressed to the following pharmaceutical companies: Dome Laboratories, Owen Laboratories, Inc., Person and Covey, Inc., Texas Pharmacal Company, Westwood Pharmaceuticals, and Lydia O'Leary Cosmetics.

References

1. Weary PE: A two-year experience with a series of rural skin and oral detection clinics. *JAMA* 217: 1862-1863, 1971.
2. Lynch FW, Lehmann FC, Pipkin JL: A contrast of cutaneous cancer as observed in Texas and in Minnesota. *Arch Dermatol* 79: 275-283, 1959.
3. Mackee BS, McGovern VJ: The mechanism of solar carcinogenesis. *Arch Dermatol* 78: 218-244, 1958.
4. Howell JB: The sunlight factor in aging and skin cancer. *Arch Dermatol* 82: 865-869, 1960.
5. *You, Your Dermatologist and Cancer of the Skin*, The American Academy of Dermatology, Portland, Oregon.
6. *Sense in the Sun*, The American Cancer Society, New York, New York.

Galen says, that immersion in cold water is fit only for the young of lions and bears; and recommends warm bathing, as conducive to the growth and strength of infants. How egregiously do the greatest men err whenever they lose sight of facts, and substitute reasoning in physic in place of observation and experience!—*William Buchan: Domestic Medicine, or a Treatise on the Prevention and Cure of Diseases by Regimen and Simple Medicines, etc.*, Richard Folwell, 1799, p. 429.

Editorials

THE 1974 MIDWINTER EXECUTIVE COUNCIL MEETING

Gas shortages notwithstanding, the Council met as usual and for the third time in the new Society building, which looks better all the time, especially since it is paid for. Dr. Tilghman Herring, who guards the Society's finances with a zeal which should satisfy any Society member familiar with his actions, announced that while 1973 was a good year as evidenced by the paying off of the building, 1974 is likely to be a very tight year for meeting the budget. The way in which our committees try to avoid spending their projected budgets is an example for all of us.

Much of the time was occupied with the Legislative Committee's reports, and what is said here will of necessity be old, for with the Legislature in session things happen fast. A bill requiring reporting of wounds seen in out-patient practice was opposed last year by the Society, and will likely not get out of committee this year. It is expected that a great deal of useful change will be brought about in the procedures affecting mental institution admission and retention practices, helping patients, families, and physicians. These changes are the result of experience with the recently changed regulations, and physician reaction to them, as well as the comments of institutional authorities. Legislation is pending which would allow the state to set up a uniform accounting procedure for various medical facilities so that cost analyses could be done; no rate enforcement authority is included. Another bill would require third party payors to establish their fee profiles on a statewide, not regional, basis. This apparently reflects the feeling of some physicians in rural areas that they are unjustly receiving less for a given procedure than another physician in an urban area. Apparently the net result of the fee schedule would be to lower fees for some urban physicians with little, if any, increase in fees in rural areas. The Council opposed this legislation. The Council went on record as disapproving a proposal to eliminate coordination of health benefits; opposition was based on the fact that this move would result in what might well be presented to the public as an increase in health care costs, including physicians' fees, when it was no such thing. This would occur because under the new legislation patients would collect the full sum available under all their medical policies for whatever illness they had.

Since they might well have to pay only a part of the money to the people and places involved in the treatment, not all the money paid them would be going for health care. Under present plans people usually do not collect more than they owe. The Council also opposed a bill requiring a reasonable suspicion of criminality before a medical examiner could order an autopsy. The state medical examiner feels and the Council concurred, that often no such suspicion exists prior to the autopsy. In the legal medicine field also is a bill which would make the presence of a blood alcohol level of 0.1 percent prima facie evidence of driving under the influence of alcohol, thus permitting no courtroom argument over that matter and removing a decision as to whether or not, determined from the jury's deliberations, the driver was intoxicated. It was suggested that members who might want to demonstrate just how a person with the 0.1 percent level feels may be assisted by local law enforcement officers at times. One member who witnessed such a demonstration was most impressed by the amount of liquor drunk before the people involved reached the legal blood level. There is a possibility that a bill will be introduced to make mandatory the wearing of seat belts, with stiff penalties if one is stopped and found not in compliance. There have been dramatic decreases in fatalities in a South American country which has such a law.

The State Board of Medical Examiners' Dr. Wilkerson reported that no applications have been received from solo nurse practitioners, but that there is interest on the part of specially trained hospital-based nurses, e.g., in coronary care units, in some special certification. Thus far no mechanism exists for such certification. Dr. Wilkerson pointed out that uncensured foreign medical graduates cannot work as physician's assistants, as some have tried to do.

The large number of other matters which were discussed will either by now have reached the membership through other channels, or represent ongoing problems on which nothing newsworthy has developed. One of the long discussions concerned primary care physicians, and a position paper, to be discussed by the House of Delegates, is to appear in the JOURNAL before they meet.

FOLK MEDICINE

Since Eve cured Adam of his delusions of immortality by administering natural food, man has required

rich and varied store of beliefs to help him preserve himself from the ever present threat of the unknown. And as the unknown has changed, so has the body of common beliefs, certainly true but unverifiable, called folklore. As Betts intimates in this issue of the JOURNAL, yesterday's scientific medicine has been absorbed into the medical underground of the present, and even today's medical indications may be altered to allow authoritative self-treatment, as witnessed by the emergence of Vitamins E and C as panaceas. If we were concerned with other disciplines, it would be legitimate to suggest that cultural lag, that delayed admission of new knowledge to the world of everyday, has been overwhelmed by the explosion in medical science in recent decades to the point that intellectual indigestion and fragmentation have set in. What would be more logical, then, than to incorporate the more apparent and simpler data of modern medicine into that incompletely codified system of folklore which offers perpetual testimony to our wishful thinking and suppressed belief in magic?

If we look to the 18th century, called The Age of Reason, we find that John Wesley, faced with a similarly exploding world, not only got the Methodist Church going but wrote a home medical advisor entitled "Primitive Physic" which passed through 19 editions in the following century and a 20th edition in this century. Wesley incorporated Indian remedies, the advice of "the great Sydenham" and many old wives' tales, into a cheap book in order to help the poor save money and to keep the apothecary and the physician from getting too rich a profit from his followers. And Wesley's advice was usually as good as, if not better than, that of his medical contemporaries who by our lights often practiced a miserable brand of therapeutics, based on ignorance and arbitrary judgment. This of course confirms that one of the elements of folklore is a measure of hard practicality, the accumulation of centuries of experience. Since we have left botanicals for chemical synthesis, this heritage becomes medical history and we forget perhaps that digitalis was elevated to the therapeutic average from such company.

Yet it behooves us not to forget this past because we find that some of our patients, seeking to expand their senses, have taken to experimenting with nature, repeating, to their chagrin, the often lethal trials of our ancestors. Such recent practices may be confirmed by

reports of cyanide poisoning from eating cherry pits, atropinism from eating fruit borne by a jimson weed—tomato graft, and the recurring reports of mushroom poisoning.

So we must be discriminating in our amusement, perceptive in our reading, and thankful that some people are interested in what contributes to the laity's notions of medicine and drugs.

JOHN H. FELTS, M.D.

Reading List

- Thompson CJS: Mystic Mandrake. New Hyde Park, New York: University Books, 1968.
 Wesley J: Primitive Physic. London: Epworth Press, 1960.
 King LS: The Medical World of the Eighteenth Century. Chicago: University of Chicago Press, 1958.
 Gibbons E: Stalking the Wild Asparagus. New York: David McKay Co Inc, 1962.
 Gibbons E: Stalking the Healthful Herbs. New York: David McKay Co Inc, 1966.

PRESCRIPTION PSRO

Several members of the North Carolina Medical Society are actively involved with pharmacists on local peer review committees in reviewing drugs purchased by recipients who are eligible under the North Carolina Medicaid program. The peer review, administered by PAID Prescriptions, is being done on a professional, confidential basis.

These committees work with computer-generated drug profiles that contain a six-month history of all prescriptions purchased by the Medicaid recipient. The computer records each patient's drug purchases and these records are sent to the practitioner.

This peer review of prescription drugs under Medicaid has been well received and has had a positive impact on both the quality of drug therapy and on the economy of the program.

On September 27, 1973, PAID Prescriptions reported to the North Carolina Medical Society Committee Liaison to the Pharmaceutical Association on the operations of the peer review program in connection with the administration of the prescription drug benefits under the Title XIX Medicaid program. The committee felt that this information was of such importance that it should be brought to the attention of the Medical Society members. The report appears in this issue of the JOURNAL and is recommended for your reading.

CHARLES W. BYRD, M.D., Chairman
 Committee Liaison to North Carolina
 Pharmaceutical Association, North
 Carolina Medical Society

When cold bathing occasions chillness, loss of appetite, listlessness, pain of the breast or bowels, a prostration of strength, or violent head-aches, it ought to be discontinued.—William Buchan: *Domestic Medicine, or a Treatise on the Prevention and Cure of Diseases by Regimen and Simple Medicines, etc.*, Richard Folwell, 1799, p. 429.

Program

Preliminary PROGRAM

NORTH CAROLINA MEDICAL SOCIETY

May 18-22, 1974

PINEHURST HOTEL
Pinehurst, North Carolina

Sunday, May 19, 1974

2:00 p.m.—OPENING SESSION — HOUSE OF
DELEGATES—Cardinal Ballroom

Monday, May 20, 1974

7:00 a.m.—MEMORIAL SERVICE/PRAYER
BREAKFAST—Crystal Room

2:00 p.m.—REFERENCE COMMITTEES meet
I—Cardinal Ballroom
II—Pine Room

7:00 p.m.—MEDPAC DINNER—Cardinal Ball-
room
(Everyone invited to attend)

9:30 p.m. Cardinal Ballroom

"SEX AFTER SUPPER"

How to help doctors keep their wives and marriages
happy

John B. Reckless, M.D.

Tuesday, May 21, 1974

2:00 p.m.—Second Session—HOUSE OF DELE-
GATES — Cardinal Ballroom

7:00 p.m.—PRESIDENT'S DINNER —
Main Dining Room

9:00 p.m.—PRESIDENT'S BALL —
Cardinal Ballroom

GENERAL SESSIONS

FIRST GENERAL SESSION

Monday, May 20, 1974 Cardinal Ballroom
9:00 a.m. — 12:30 p.m.

Convene Session

Presiding: George G. Gilbert, M.D., President,
Asheville

Invocation:

Surgical Session

CONTEMPORARY SURGICAL MANAGEMENT

Department of Surgery, University of North
Carolina, School of Medicine, Chapel Hill,
North Carolina

MODERATOR: Colin G. Thomas, Jr., M.D.
Professor and Chairman
Department of Surgery

9:00 a.m.—OPENING REMARKS —

Christopher C. Fordham, III, M.D., Dean
University of North Carolina School of Medicine

9:15 a.m.—CANCER OF THE LUNG

Gordon F. Murray, M.D.,
Assistant Professor of Surgery
Division of Cardiovascular and
Thoracic Surgery

9:30 a.m.—PAIN CONTROL — Microneuro-
surgery

Frederic I. Fagelman, M.D.
Assistant Professor, Division of
Neurosurgery

9:45 a.m.—IMPROVED NUTRITION — PAR-
ENTERAL ALIMENTATION
AND ELEMENTAL DIET

Robert D. Croom, III, M.D.,
Assistant Professor, General Surge-

10:00 a.m.—SURGICAL RESTORATION OF
THE VOICE

W. Paul Biggers, M.D., Associate
Professor, Surgery, Otolaryngology

10:15 a.m.—TREATMENT OF THE BURN
INJURY

A. G. Bevin, Jr., M.D., Associate
Professor, Plastic Surgery

10:30-10:45 a.m.—BREAK

10:45 a.m.—NEW DEVELOPMENTS IN OR-
THOPAEDICS

Edwin T. Preston, M.D., Assistant
Professor, Surgery, Orthopaedics

11:00 a.m.—IMMUNOLOGICAL ADVANCES
IN UROLOGICAL TUMORS

Andrew T. Cole, M.D.,
Assistant Professor, Surgery, Uro-
logy

11:15 a.m.—NON-INVASIVE ESTIMATES OF
PERIPHERAL BLOOD FLOW

Noel B. McDevitt, M.D.,
Assistant Professor, Vascular Sur-
gery

1:30 a.m.—END STAGE RENAL DISEASE —
ROLE OF COMMUNITY HOS-
PITAL
Stanley R. Mandel, M.D.,
Associate Professor, Vascular Sur-
gery

2:00 Noon—
AWARDING OF DOOR PRIZES
ADJOURN

SECOND GENERAL SESSION

Tuesday, May 21, 1974 Cardinal Ballroom
9:00 a.m. — 12:30 p.m.

Convene Session

Presiding: D. E. Ward, Jr., M.D., First Vice Presi-
dent, Lumberton

Medical Session

Bowman Gray Day

Department of Medicine, Bowman Gray School
of Medicine, Winston-Salem, North Carolina

9:00 a.m.—WHAT'S NEW AT BOWMAN GRAY
Richard Janeway, M.D., Dean
Bowman Gray School of Medicine

9:10 a.m.—INTRODUCTION
Joseph E. Johnson, M.D.,
Professor and Chairman
Department of Medicine

9:20 a.m.—THE PROBLEM OF HYPERTEN-
SION: AN OVERVIEW
Robert N. Headley, M.D.,
Associate Professor of Medicine

9:45 a.m.—HYPERTENSION AND THE
HEART
John H. Edmonds, Jr., M.D.,
Professor of Medicine

10:05 a.m.—HYPERTENSION AND CEREBRO-
VASCULAR ACCIDENT
Richard Janeway, M.D., Dean

10:20 a.m.—BREAK

10:35 a.m.—RENIN, ALDOSTERONE AND
THE KIDNEY
Vardaman Buckalew, M.D.,
Professor of Medicine

11:00 a.m.—PHEOCHROMOCYTOMA
John S. Kaufmann, M.D., Assistant
Professor, Medicine and Pharma-
cology

11:30 a.m.—THERAPY OF HYPERTENSION
John H. Felts, M.D.,
Professor of Medicine

12:00 Noon—Address: George G. Gilbert, M.D.,
President, Asheville

AWARDING OF DOOR PRIZES
ADJOURN

THIRD GENERAL SESSION

Wednesday, May 22, 1974 Cardinal Ballroom
9:00 a.m.-12:30 p.m.

Convene Session

Presiding: George G. Gilbert, M.D., President
Asheville

SOCIO-ECONOMIC SESSION

MODERATOR: Josephine E. Newell, M.D., Bailey

9:00 a.m.—CONJOINT SESSION — NORTH
CAROLINA DIVISION OF
HEALTH SERVICES AND
NORTH CAROLINA MEDI-
CAL SOCIETY

Jacob Koomen, M.D., Director,
Raleigh

9:30 a.m.—PAST MISTAKES — FUTURE EX-
PECTATIONS — HOW TO
PLAY THE SECOND HALF

Edward R. Annis, M.D.,
Physicians Planning Service Corpo-
ration, New York, New York

10:30 a.m.—Address: Russell B. Roth, M.D., Presi-
dent, American Medical As-
sociation, Erie, Pennsylvania

11:15 a.m.—Address: Frank R. Reynolds, M.D.,
President, North Carolina
Medical Society

11:45 a.m.—Awarding of Prizes.
ADJOURN SINE DIE

SECTION ON ANESTHESIOLOGY

Saturday, May 18, 1974 HMS Bounty
9:00 a.m.-11:30 a.m.

Chairman: Mercl H. Harmel, M.D., Durham

SECTION ON NEUROLOGY & PSYCHIATRY

Saturday, May 18, 1974 Pine Room
9:00 a.m.-12:00 Noon

Chairman: Robert W. Gibson, M.D., Morganton
12:30 p.m.

Dutch Luncheon and Business Meeting

Crystal Room

#

SECTION ON PATHOLOGY

Saturday, May 18, 1974 Ballroom, Holly Inn
9:00 a.m.-5:00 p.m.

Chairman: James A. Maher, M.D., Goldsboro

LIVER BIOPSY INTERPRETATION

Joseph W. Grisham, M.D., Professor and Chairman
Department of Pathology, Univ. of North Carolina
School of Medicine, Chapel Hill

RECENT DEVELOPMENTS IN CLINICAL LAB- ORATORY STANDARDS —

Development of Consensus Standards Analogous to
Industry—a recent phenomenon

Robert W. Prichard, M.D., Professor and Chair-
man, Department of Pathology, Bowman Gray
School of Medicine, Winston-Salem

CLINICAL AND STATISTICAL INTERPRETA- TION OF ELECTROIMMUNO ASSAY IN

IDENTIFICATION OF BODY FLUID PROTEIN ABNORMALITIES

Florian Menninger, M.D., Mason Research
Institute, Worcester, Massachusetts

BUSINESS MEETING—North Carolina State Pathology Society

Election of Officers, Delegate and Alternate Delegate
for the Section for 1974-75

ADJOURN

#

SECTION ON ORTHOPAEDICS and NORTH CAROLINA ORTHOPAEDIC ASSOCIATION

Saturday, May 18, 1974 Pine Room

Chairman: Robert J. Burleson, M.D., Asheville

12:30 p.m.—Executive Committee Meeting of
North Carolina Orthopaedic Association

1:00 p.m.—Lunch—(On your own)

2:00 p.m.—North Carolina Orthopaedic Association, Spring Meeting

3:00 p.m.—Section on Orthopaedics Meeting

4:00 p.m.—Adjournment

#

SECTION ON RADIOLOGY

Saturday, May 18, 1974 Cardinal Ballroom

1:30 p.m.—5:00 p.m.

Chairman: Stuart W. Gibbs, M.D., Gastonia

**EVALUATION OF PATIENTS WITH SUDDEN
FLANK PAIN AND HEMATURIA WHO DO
NOT HAVE STONES**

Jerome Cunningham, M.D.,

Department of Radiology, North Carolina
Baptist Hospital, Winston-Salem

**RECENT ADVANCES IN NUCLEAR MEDICINE
RENOGRAPHY**

Edward V. Staab, M.D., Professor of Radiology
and Director of Nuclear Medicine Division,
Department of Radiology, N. C. Memorial
Hospital, Chapel Hill

—

INTERMISSION

—

RENAL SHUNTS AND THE TRUETA PHENOMENON IN MAN

Milton Elkin, M.D., Professor of Radiology,
Albert Einstein College of Medicine, Bronx,
New York

OPPORTUNISTIC PULMONARY INFECTIONS

Arvin Robinson, M.D., Department of
Radiology, Duke University Medical Center,
Durham

BUSINESS SESSION—Election of Officers, Delegate and Alternate Delegate
for 1974-75

ADJOURN

SECTION ON DERMATOLOGY

Saturday, May 18, 1974

6:30 p.m.—SOCIAL HOUR—Poolside

7:30 p.m.—DINNER and Entertainment—

Cardinal Ballroom

#

SCIENTIFIC SESSION

Sunday, May 19, 1974 Crystal Room

9:00 a.m.—12:00 Noon

SYMPOSIUM ON CONTACT DERMATITIS

Guest Speaker: Alexander Fisher, M.D.

Clinical Professor of Dermatology
New York University

Business Session: Election of Officers, Delegate and
Alternate Delegate for 1974-75

#

SECTION ON FAMILY PHYSICIANS

Sunday, May 19, 1974 Pine Room

9:00 a.m.—12:00 Noon

Chairman: A. M. Alderman, Jr., M.D., Raleigh
and

BOARD OF DIRECTORS Meeting—North Carolina
Academy of Family Physicians

#

SECTION ON SURGERY

Monday, May 20, 1974 London Gr

7:30 a.m.

Chairman: Wm. B. McCutcheon, Jr., M.D., Durham
Breakfast Meeting—

Election of Officers, Delegate and Alternate
Delegate for year 1974-75

#

SECTION ON OBSTETRICS & GYNECOLOGY

Monday, May 20, 1974 Pine Room

8:00 a.m.—9:00 a.m.

Chairman: Robert G. Brame, M.D., Durham
BUSINESS MEETING—Election of Officers, Delegate and Alternate Delegate
for 1974-75

#

SECTION ON PUBLIC HEALTH AND EDUCATION

Monday, May 20, 1974 TV Lounge, Holly I

2:00 p.m.

Chairman: John J. Wright, M.D., Chapel Hill
Program Chairman: Isa C. Grant, M.D., Raleigh

NUTRITION EVALUATION PROJECT

Joseph C. Edozien, M.D., Professor and
Head of Nutrition
School of Public Health, Chapel Hill

BUSINESS MEETING—Section on Public Health
Education and North Carolina Academy of
Preventive Medicine

Election of Officers, Delegate and Alternate
Delegate for 1974-75

SECTION ON PEDIATRICS

Monday, May 20, 1974 Crystal Room
2:00 p.m.-4:30 p.m.

Chairman: William W. Farley, M.D., Raleigh
Program Chairman: Ronald P. Krueger, M.D., Durham

UROLOGIC PROBLEMS OF CHILDHOOD COMMON URINARY TRACT MALFORMATIONS OF CHILDHOOD

Patrick Currie, M.D., Division of Urology
Bowman Gray School of Medicine, Winston-Salem

SICO-URETERAL REFLUX: ETIOLOGY, SIGNIFICANCE AND MANAGEMENT

John Weinerth, M.D., Division of Urology
Duke University School of Medicine, Durham

CURRENT URINARY TRACT INFECTIONS

William G. Conley, M.D., Department of Pediatrics, University of North Carolina School of Medicine, Chapel Hill

ANTIBACTERIAL THERAPY OF URINARY TRACT INFECTIONS

Catherine Wilfert, M.D., Department of Pediatrics, Duke University School of Medicine, Durham

MANAGEMENT OF THE CHILD WITH ADVANCED RENAL DAMAGE

C. Richard Morris, M.D., Department of Pediatrics, University of North Carolina School of Medicine, Chapel Hill

UROLOGIC EVALUATION OF THE GENITOURINARY TRACT IN CHILDREN

Herman Grossman, M.D., Department of Radiology, Duke University School of Medicine, Durham

JOINT TABLE DISCUSSION AND QUESTIONS FROM THE AUDIENCE: UROLOGIC PROBLEMS OF CHILDHOOD—

Drs. Currie, Weinerth, Conley, Wilfert, Morris and Grossman

Business Session: Election of Officers, Delegate and Alternate Delegate for the year 1974-75

This program will be of interest to General Practitioners as well as Pediatricians)

#

SECTION ON OPHTHALMOLOGY & OTOLARYNGOLOGY

Monday, May 20, 1974 Ballroom, Holly Inn
2:00 p.m.-4:30 p.m.

Chairman: E. Randolph Wilkerson, Jr., M.D., Charlotte

2:00 p.m.—Scientific papers—by Ophthalmologists

2:00 p.m.—BUSINESS MEETING —

Discuss establishing:

- a) Section on Ophthalmology
- b) Section on Otolaryngology

Election of Officers, Delegate and Alternate Delegate for each Section for 1974-75

3:30 p.m.—Scientific papers—by Otolaryngologists
#

ORGANIZATIONAL MEETING FOR NEUROSURGERY

Tuesday, May 21, 1974 Parlor No. 129
(East Wing)

9:00 a.m.

Chairman: Ira M. Hardy, III, M.D., Greenville
#

SECTION ON UROLOGY

Tuesday, May 21, 1974 Pine Room
10:00 a.m.

Chairman: Vernon H. Youngblood, M.D., Concord

POSTGRADUATE AND AUDIO-VISUAL PROGRAM

ONE HUNDRED TWENTIETH ANNUAL SESSION

Pinhurst, North Carolina

G. Patrick Henderson, Jr., M.D., *Chairman*, Pinhurst

Morning Session

Monday, May 20, 1974

9:00 a.m.-12:00 Noon HMS Bounty

Moderator: Thornton R. Cleek, M.D., Asheboro

9:00 a.m.—CHARLIE

Emphasizes the importance that drinking and flying do not mix. Charlie's judgment and his life are changed by alcohol, even a small bit of alcohol.

9:25 a.m.—DIAGNOSIS AND TREATMENT OF RENOVASCULAR HYPERTENSION

Approximately 5% of those who have elevated blood pressure have surgical correctable lesions. The vigorous and intensive medical and neurological investigation acquired to find these patients with potentially curable hypertension is carefully and thoroughly illustrated.

9:55 a.m.—LAPAROSCOPY

Diagnostic and Therapeutic operative technique has come into its own since the advent of fiber optics. An over-view of the procedure, including instrumentation, operative team, and technique is presented.

10:20 a.m.—FIRE UNDER CONTROL

Brief review of hazards of fire in

everyday living and specifically in manned space flight.

10:35 a.m.—ALL IT TAKES IS ONCE

Even the best pilots can be distracted in flight by pre-occupation with personal problems. Mental distraction is a serious problem in flight. How five psychological problems frequently encountered by general aviation pilots—affects of their performance is adequately presented.

11:05 a.m.—UNCOVERING DEPRESSION IN THE ANXIOUS PATIENT

Intended to reinforce the importance of stop, look and listen, in actual practice. Encourage a physician to take time to explore possibility of a hidden depression in every patient who presents with obvious anxiety.

11:35 a.m.—RX FOR HEALTH CARE

Correlates the root causes for health crises and the proposal for dealing with these concerns.

#

Afternoon Session

Monday, May 20, 1974

2:00 p.m.-5:00 p.m. HMS Bounty
Moderator: John L. Monroe, M.D., Pinehurst

2:00 p.m.—THE ROLE OF THE PRACTICING PHYSICIAN IN THE INVESTIGATION OF A SUDDEN, UNUSUAL, UNNATURAL OR SUSPICIOUS DEATH

Slides from the office of R. Page Hudson, Jr., M.D., Chief Medical Examiner, State of North Carolina, Chapel Hill.

3:00 p.m.—THE NOSE AND PARANASAL SINUSES

The gross anatomy and physiology of the nose and paranasal sinuses are emphasized. Causes of chronic maxillary sinusitis, atrophic rhinitis, polyposis, septum deviation, foreign body, and carcinoma are diagnosed and discussed.

3:30 p.m. THE TREATMENT OF DEAFNESS

A presentation of experimental and clinical observations on which the use of prosthetic appliances in the tympanic cavity is based.

4:05 p.m.—CAN WE HAVE A LITTLE QUIET, PLEASE?

This is an illustration how government and industry are cooperating to reduce aircraft smoke emissions and noise, particularly around air-

ports, and describes technical improvements that have been made to jet engines and sound abatement procedures.

4:25 p.m.—OTOSCOPY IN INFLAMMATORY

An illustration of the tympanic membrane pathology, from acute and chronic catarrhal conditions to the adhesive process. Chronicities are analyzed and discussed.

#

Morning Session

Tuesday, May 21, 1974

9:00 a.m.-12:00 Noon

HMS Bounty

Moderator: John C. Grier, Jr., M.D., Pinehurst

9:00 a.m.—THREE TIMES A DAY

One out of every four Americans in the 55 to 62 age group will suffer coronary, diet being one of the chief causes. Up to 70% of our population should take steps to lower the cholesterol levels, evidence through research.

9:30 a.m.—ESCAPE FROM ADDICTION

A comprehensive and organized picture of chemical dependence—straight forward unemotional matter. A broad view of addiction—it relates to alcohol, narcotics, other drugs.

10:05 a.m.—THE MEDICAL WITNESS

An illustration to help the physician make an effective transition from medical examining room to court room. The film uses examples to dramatize the right and wrong way to give medical testimony. Gives special emphasis to proper preparation.

10:40 a.m.—SPRINGBOARD TO SPACE

An illustration how astronaut chemistry, physics, mathematics, engineering, medicine and other academic areas will pioneer a way to creativity and comprehension in conquering the unknown.

11:00 a.m.—URETHRAL CATHETERIZATION OF MALE AND FEMALE

The various purposes for, and methods of urethral catheterization are discussed as are the types and composition of catheters. Procedures for catheterization are fully illustrated.

11:20 a.m.—QUALITY ASSURANCE PROGRAM

An illustration of the PSRO System. Tell exactly what the PSRO

System is, exactly how it is intended to work.

#

Afternoon Session
Monday, May 21, 1974

10 p.m.-5:00 p.m. **HMS BOUNTY**
Lecturer: Paul McB. Abernethy, M.D., Burlington

10 p.m.—**RECOGNIZING GLAUCOMA**

This film reviews the different types of glaucoma and demonstrates how glaucoma can be recognized by measurement of intraocular pressure.

10 p.m.—**THE MANAGEMENT OF SEVERE BURNS IN CHILDREN**

This demonstrates the treatment upon arrival of one patient in the emergency room immediately following a burn accident. Treatment

is followed through the successful completion of grafting.

3:00 p.m.—**THE MAN WHO DIDN'T WALK**

Dramatizes one of the most controversial issues in the entire catalog of medico-legal problem . . . traumatic neurosis.

3:40 p.m.—**A MATTER OF FACT**

An innocent man is nearly indicted for murder. Illustrates the necessity for alert and keen observation on the part of any doctor who establishes the cause of death.

4:15 p.m.—**MEDITATIONS ON HUNTING**

More than 20-million American hunters take to the field each year. This film is an intellectual and cultural justification for hunting today.



program and environment
the individual to maintain
respect and recover with



examination upon admis-



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temperature control.



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Emergency Medical Services



ACTIVITIES OF THE PUBLIC HEALTH SERVICE IN EMERGENCY MEDICAL SERVICES

**Robert van Hoek, M.D., Acting Director
Bureau of Health Services Research and Evaluation
Health Resources Administration
Department of Health, Education and Welfare**

In 1972, President Nixon directed HEW to utilize existing knowledge and management concepts to upgrade emergency medical services. The task focused on increasing the rapidity with which the accident victim could enter an effective emergency care network. The components of such a system include the extension of services into areas where on-site medical help is unavailable, improved communication systems, recruitment and training of supportive paramedical personnel, and more effective transportation of patients.

This led to the formation of an Emergency Medical Services program (EMS) which has provided technical assistance to local areas, collected and distributed information, and established seven demonstration systems intended to improve local services and to evaluate new approaches.

1. Illinois—expansion of statewide trauma treatment system into a state-wide emergency medical system. Plans include radio networks between hospitals and ground and air vehicles, physician-monitored ambulance systems, and regional central emergency medical control centers.

2. Arkansas—organization and planning of a coordinated EMS system among the state's districts. Specific objectives are training of paramedics and ambulance drivers, a radio network, and an ambulance system.

3. Jacksonville, Florida—expansion of a city-oriented EMS unit to surrounding rural counties by up-

grading local ambulance services, hospital ERs, and training of all law enforcement officers and firemen.

4. San Diego, Imperial, Riverside counties, California—coordination of separate EMS systems into a single entity with a radio network, training program for ambulance attendants, park rangers, and people in remote areas, and other specific programs.

5. Seven Ohio counties—establishment of a cooperative EMS system. Novel features include training programs in the community college system and educational programs to acquaint citizens with the services.

6. Baltimore, Maryland—implementation of a radio-telephone network to facilitate transport of victims to the most appropriate medical facility.

7. Arizona—establishment by the Dept. of Public Safety of a model communications system including training interstate truck drivers equipped with portable radios to report accidents.

In addition, an interdepartmental EMS committee has been formed involving multiple agencies to coordinate federal EMS activities. The Administration has requested \$15 million for FY 1974 for EMS support the demonstrations and provide technical assistance and consultation to local areas. The funding, if appropriated, will be administered by the Bureau of Health Services Research and Evaluation, Health Resources Administration, Department of Health, Education and Welfare.

Abstracted by EDWARD H. WAGNER, M.D.

From "Emergency Medicine Today," AMA Commission on Emergency Medical Services, Volume No. 12, John M. Howard, M.D., Editor. Original article can be obtained from the American Medical Association, 535 North Dearborn Street, Chicago, Illinois 60610.

Strong stimulants applied to the stomach and bowels for a length of time, must tend to weaken and destroy their energy; and what stimulants are more active than salt and sulphur, especially when these substances are intimately combined, and carried through the system by the penetrating medium of water? These bowels must be strong indeed, which can withstand the daily operation of such active principles for months together, and not be injured. This is the plan pursued by most of those who drink the purging mineral waters, and whose circumstances will permit them to continue long enough at those fashionable places of resort.—*William Buchan: Domestic Medicine, or a Treatise on the Prevention and Cure of Diseases by Regimen and Simple Medicines, etc. Richard Folwell, 1799, p. 431.*

Committees and Organizations

Report to the NORTH CAROLINA MEDICAL SOCIETY COMMITTEE LIAISON TO THE PHARMACEUTICAL ASSOCIATION

September 27, 1973

PAID Prescriptions is a non-profit corporation specializing in prescription drug claims processing and pharmacy program administration. On December 1972, PAID Prescriptions entered into a contract with the North Carolina Department of Social Services to administer the prescription drug benefits under the Title XIX Medicaid program.

One of the requirements of this contract called for PAID to administer a program of drug utilization review based on the successful peer review program that PAID had administered for Medicaid recipients in California under a contract with the San Joaquin Foundation for Medical Care.

For the purpose of peer review, North Carolina was divided into four geographic regions, each having approximately 75,000 eligible Medicaid recipients. Six pharmacists and one physician were selected for membership on each of the four committees to meet once a month in their respective areas.

Prior to implementation, representatives from PAID Prescriptions met individually with the Chairman and Commissioner of this committee. They also met with key Medical Society members and staff at their headquarters in Raleigh. President Glasson suggested that a centrally located county in each region select a physician for membership on the local committee. At this meeting, form letters were designed for communicating information to the physicians. These letters were written with special tact and professionalism. A simple reply form, designed to allow the physician to quickly report the necessary information, has been a major factor in the success of our program. The importance of receiving this information from the practitioner cannot be overemphasized.

The core of the drug utilization review program is the computer-generated patient drug profile. These profiles are generated automatically each month if the patient's drug utilization exceeds the following parameters within that month:

1. Twelve or more prescriptions.
2. \$70.00 or more total drug cost.
3. Four or more prescriptions in one therapeutic category.

4. Four or more physicians.
5. Three or more pharmacies.
6. The same drug purchased in more than one pharmacy, on the same day.

These parameters are not necessarily indicative of problems, but they have been found to identify a high incidence of problems.

A patient profile contains a six-month history of drug purchases. These profiles are reviewed by the peer review committees at their regular meetings. If either the dispensing or utilization shown on the profile cannot be explained, a copy of the patient's profile, along with a letter requesting additional information that can be added to the patient's profile, is sent to the practitioner. In the instances of large numbers of patients visiting more than one physician and one pharmacy, our greatest asset is the computer-generated drug profiles with which we furnish the physicians and pharmacies involved. This information is completely confidential. Both pharmacist and physician are identified by numbers that are unknown even to the peer review committee at the time of the review.

Problems in the program have been in one of three areas:

1. Frequent dispensing of small quantities of maintenance medication.
2. Apparent overutilization of medication by the patient.
3. Apparent overutilization involving more than one pharmacy or physician. (One case involved nine physicians and seven pharmacies within a calendar month).

Abuse in any of these three areas increases program expenditures. Therefore, a reduction in drug cost is usually consistent with either an improvement in program economy or in patient drug therapy. For this reason, we measure the effect of the peer review by comparing the cost per day, of the drug under review, on a "before and after" basis.

Comparisons have been completed for the first two months' meetings in each of the four regions. The results are as follows:

RESULTS OF TWO-MONTH COMPARISON

	Number
Profiles reviewed	6,500
Profiles selected for further action	585
Profiles compared	458 (78%)

Letters to pharmacists	814
Replies from pharmacists	610 (75%)
Letters to physicians	278
Replies from physicians	162 (58%)
Drugs considered (for 458 patients)	896
Drugs with decrease in utilization following review	708 (79%)
Drugs with increase in utilization following review	173 (19%)
Drugs unchanged following review	15 (2%)
* * *	
Total reduction in cost of drug per day (for 458 patients)	\$196.25
Average reduction in cost of drug per day per patient	\$.43

In order for us to fully understand the potential of these savings to the program, we have projected these savings for a period of twelve months (365 days):

\$0.43 per day x 365 days = \$156.40 per patient, per year

We can assume that this average savings will hold true for each of the 585 patients reviewed:

\$156.40 per patient, per year x 585 patients reviewed = \$91,495.00 potential reduction in drug cost per year resulting from two months of peer review.

The results from these first two months have been most impressive. We have received many replies from physicians thanking us for the information they have received, as well as many compliments on this type of review.

ACKNOWLEDGMENT

On behalf of PAID Prescriptions, I would like to express my sincere appreciation to the North Carolina Medical Society and its members for the cooperation and assistance they have given us in the peer review program.

Frank F. Yarborough, Director
PAID Prescriptions
P. O. Box 18964
Raleigh, N. C. 27609

* * *

COMMITTEE ADVISORY TO CRIPPLED CHILDREN'S PROGRAM

Southern Pines, Sept. 26, 1973

The chairman reported that the committee had received a request from the State Board of Health for assistance in developing a protocol for the evaluation of an institution which had made application to receive benefits under the Crippled Children's Program. It was the consensus of the committee that:

The State Board of Health should draft certain criteria and guidelines, noting number of physicians as well as specialties, and set forth certain criteria

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OWEN W. BRODIE, M.D.
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WESLEY E. McENTIRE, M.D.
Associate in Psychiatry

BOBBY W. NELSON, M.D.
Associate in Psychiatry

NEUROLOGY

GERALD W. ATKINSON, M.D.
Associate in Neurology

HUGH HOWELL, M.D.
Associate in Neurology

CHILD PSYCHIATRY

GILBERT SILVERMAN, M.D.
Associate in Child Psychiatry

ADMINISTRATION

H. R. WOODALL
Administrator

th which an institution could be measured in order receive certification for payment.

—ROBERT G. UNDERDAL, M.D., *Chairman*

* * *

COMMITTEE TO WORK WITH THE N. C. INDUSTRIAL COMMISSION

Southern Pines, Sept. 27, 1973

Following a discussion concerning efforts of the committee and the Industrial Commission to adopt

policy of basing payment for physicians' services in Workmen's Compensation cases on the "usual, customary, and reasonable concept," and the fact that the Workmen's Compensation Fee Schedule was updated in 1971 and again in 1973, a motion was made to the effect that:

This committee recommends that the Industrial Commission update the Workmen's Compensation Fee Schedule again in May of 1975 and every two years thereafter.

—ERNEST B. SPANGLER, M.D., *Chairman*

Bulletin Board

NEW MEMBERS of the State Society

Abraham, Everett Harold, Jr. (Student), 1301 Brookstown Avenue, Apt. 301, Winston-Salem 27103
Boughten, Robert Allen (Student), 1720 Grace St., Winston-Salem 27103
Beh, Patrick Glenn (Student), 3830-D Huntinggreen Lane, Winston-Salem 27106
Bikes, Peter George (Intern-Resident), 3803 Tremont Dr., Durham 27705
Carch, Karolen Ruth (Student), 817 S. Hawthorne Rd., Winston-Salem 27103
Caton, Calvin Porter, Jr., M.D. (CDS), Doctors' Pk., Suite 512, Asheville 28801
Cory, Jimmie Ray, M.D. (GP) (Former Member), Stanleyville Shopping Center, Route 1, Rural Hall 27045
Cowie, Rick Edmund (Student), 1505 Woods Rd., Apt. 103, Winston-Salem 27106
Don, Sewell Hinton, Jr., M.D. (CDS), 1016 Prof. Village, Greensboro 27401
Don, Ellen Maurine (Student), 2029 Elizabeth Ave., Winston-Salem 27103
Edwards, Joel Lynn (Student), 2046 Queen St., Winston-Salem 27103
Felt, Stephen Mart (Student), 4670 Elk Valley Court, Winston-Salem 27103
Go, Peter Paul, M.D. (D), 120 Randomwood Lane, New Bern 28560
Giffin, Adrian Mark (Student), 660 Brent St., Winston-Salem 27103
Hack, Seymour Leon, M.D. (P), 500 Laurel Hill Road, Chapel Hill 27514
Her, Robert Norment, Jr. (Student), 624 W. End Blvd., Apt. 6, Winston-Salem 27101
Hy, Grant Fletcher (Student), 2021 Elizabeth Ave., Winston-Salem 27103
H, Elzie Franklin, Jr. (Intern-Resident), Windsor Circle, Chapel Hill 27514
Jacks, Albert Connor, III, M.D. (IM), 3812 Canterbury Ln., Wilmington 28401
Kry, David Fulmer (Student), 337 Crafton St., Apt. 2, Winston-Salem

Lang, Delano Roosevelt, Jr., M.D. (GP), 705 E. Sunset Ave., Ahoskie 27910
Lewis, Clifford Thomas, Jr., M.D. (IM), 913 Hood Dr., Wilmington 28401
Norton, Michael (Student), 3830-A Huntinggreen Lane, Winston-Salem 27106
Olson, Maynard, Robert (Student), 1930 Gaston St., Winston-Salem 27103
Pierce, Charles Grainger (Student), 411 N. Columbia St., Chapel Hill 27514
Plemmons, Ronald Lawrence (Student), P. O. Box 5922, Winston-Salem 27103
Powell, James Bobbitt, M.D. (PTH), 810 W. Davis St., Burlington 27215
Prokos, Craig Philip (Student), 2520 Preston Ave., Durham 27705
Reeves, Michael Leo (Student), 438 S. Hawthorne Rd., Apt. B, Winston-Salem 27104
Roach, John Grover, III (Student), 1950 Hinshaw Ave., Winston-Salem 27104
Rock, John Aubrey, M.D. (Intern-Resident), Box 2984, Duke Med. Center, Durham 27710
Sanders, Fredrick Douglas (Student), 1266 Tredwell Dr., Winston-Salem 27103
Scholl, George Kenneth, Jr., M.D. (U), 100 Manning Dr., Charlotte 28209
Shanahan, Eugene, M.D. (GP), 125 N. Main St., Spring Lake
Suarez, Jaime, M.D. (Intern-Resident), Station B., Box 7441, Raleigh 27611
Thakur, Veda Nand, M.D. (ORS), 14th and Chesnut St., Lumberton 28358
Thomas, John Barham Ragland, M.D., 644 Fenimore St., Winston-Salem 27103
Vogler, James Brevard, III (Student), 1403 Pilot View St., Apt. D, Winston-Salem 27103
Walker, John Barrett, III (Student), 1900 Queen St., Apt. B-7, Winston-Salem 27103
Whitesides, John Harvey, M.D. (OBG), 1509 Elizabeth Ave., Charlotte 28204
Williamson, Warren Ligon, M.D. (GS), P. O. Box 1171, Lumberton 28358
Woodall, Hal Breeden (Student), 2863 Hermitage Dr., Winston-Salem 27103
Yopp, James Dennie, Jr., M.D. (IM), 3010 Maplewood Dr., Suite 122, Winston-Salem 27103
Yount, James Alvin, M.D. (IM), 3535 Randolph Road, Charlotte 28211

WHAT? WHEN? WHERE?

March 1974

("Place" and "sponsor" are listed only where these differ from the place and group or institution listed under "for information.")

In North Carolina

March 15-16

Tenth Annual E. C. Hamblen Symposium in Reproductive Biology and Family Planning. Basic themes: The Management of High-Risk Obstetrics and Newer Advances in the Treatment of Infertility

Sponsor: Department of Obstetrics and Gynecology

Tuition: \$25.00; no charge for residents or students

For Information: Charles B. Hammond, M.D., P. O. Box 3143, Duke University Medical Center, Durham 27710

March 21-23

Hematology and Oncology Post Graduate Course

Place: Duke University School of Medicine

Director: Wayne Rundles, M.D., Professor of Hematology, Duke University

For Information and registration forms: American College of Physicians, 4200 Pine Street, Philadelphia, Pennsylvania 19104

March 25-27

Tutorial Postgraduate Course: Radiology of the Chest

This course is designed both for radiologists in training and those in practice. The tutorial format and limited registration will allow a larger than usual faculty-student ratio and personalized instruction to those enrolled. Guest faculty have been chosen both for their excellence in their respective topics, and for their effective use of the tutorial approach. During one hour tutorial sessions 12 registrants will join one faculty member in a separate quiet room with a bank of viewboxes for organized film reading-discussions, with 10-12 case presentations on a basic subject or two. Registrants are invited to bring interesting cases for consultation with the "experts."

Place: Durham Hotel-Motel, Durham

Credit: 21 hours AMA "Category One" accreditation

Fee: \$200.00

For Information: Robert McLelland, M.D., Department of Radiology, Box 3808, Duke University Medical Center, Durham 27710

March 26-28

Cardiac Arrhythmia Course

Place: Duke Hospital Orthopedic Clinic, Room 1367

For Information: Galen Wagner, M.D., Box 3327, Duke University Medical Center, Durham 27710

March 28

"The Fit and the Fat—Our Overweight, Coronary Prone Society," The 9th Wilson Memorial Hospital Postgraduate Symposium

Sponsors: Wilson County Medical Society and the North Carolina Academy of Family Physicians

Credit: The Continuing Education Programs of Wilson Memorial Hospital are fully accredited by the Council on Medical Education of the AMA, and are acceptable for credit toward the AMA Physician's Recognition Award. Credit from the AAFP has been requested.

For Information: Gloria Graham, M.D., Wilson Memorial Hospital, Wilson 27839

April 1-2

Postgraduate Course: Obstetrics and Gynecology

Place: Babcock Auditorium

For Information: Emery C. Miller, M.D., Associate Dean for Continuing Education, Bowman Gray School of Medicine, Winston-Salem 27103

April 5-6

AMA-Southeast Regional Mental Health Conference

Place: Marriott Hotel, Atlanta, Georgia

Sponsors: AMA Council on Mental Health and the com-

mittees responsible for mental health in the state medical associations of Florida, Georgia, Kentucky, North Carolina, South Carolina and Tennessee

Fee: \$25.00

For Information: Philip G. Nelson, M.D., Medical Pavilion, Greenville 27834

April 8-9

Anglo-American Conference on Continuing Medical Education

Sponsors: The Royal Society of Medicine Foundation, London; The Royal Society of Medicine, London; University of North Carolina School of Medicine

Program: In addition to speakers of national prominence and from abroad, tours of points of interest will be conducted for ladies, and a number of social events are being arranged for delegates and their spouses.

Fee: Delegates, \$100; delegate and spouse, \$150

For information: Office of Continuing Education, 119 Medical Nider Building, UNC School of Medicine, Chapel Hill 27514

April 20

Present Concepts On Knee Problems

Place: Royal Villa Hotel, Raleigh

Sponsor: American Academy of Orthopaedic Surgeons (Produced by The Committee on Adult Musculoskeletal Diseases)

Fee: \$40; residents \$20. Registration limited to 100.

Credit: Approved for five prescribed hours by AAFP

For information: Thomas B. Dameron, Jr., M.D., P. O. Box 10707, Raleigh 27605

April 24-25

Third Annual Cancer Symposium

Place: Downtown Holiday Inn, Raleigh

Sponsors: North Carolina Central Cancer Registry; North Carolina Regional Medical Program; American Cancer Society, North Carolina Division

For information: Cory Menees, Cancer Program Manager, P. O. Box 2091, Raleigh 27602

April 26-28

Annual Meeting of the American Association of Medical Assistants, North Carolina State Society

Place: Hilton Motel, Winston-Salem

Program: Keynote Speaker, George G. Gilbert, M.D., President, North Carolina Medical Society. Mr. M. Silver of Conomikes Associates will present a program on managing the patient, the office, and the physician. Physicians and their assistants are urged to attend.

Fee: \$30

For information: Mrs. June Aysse, 911 Hay Street, Winston-Salem 27103, Box 3514, Fayetteville 28305

April 27

Craven-Pamlico Annual Medical Society Symposium

Place: Ramada Inn, New Bern

For Information: Zack J. Waters, M.D., 800 Hospital Drive, New Bern 28560

May 1

Diabetic Complications: Are They Preventable?, a one-day symposium

Place: The Governor's Inn, Research Triangle Park

Sponsors: North Carolina Diabetes Association and the Department of Medicine, Duke University Medical Center

Fee: \$15

For Information: Jerome M. Feldman, M.D., Box 3808, Duke University Medical Center, Durham 27710

May 4-5

Principles of Practical Oxygen Therapy, which had been scheduled for this date, has been postponed until May 11

For Information: Miss Ann Francis, Administrative Assistant, Office of Continuing Education, School of Medicine, UNC, Chapel Hill 27514

May 9-10

Breath of Spring '74—Respiratory Care Symposium

Place: Babcock Auditorium

For Information: Emery C. Miller, M.D., Associate

OFFICIAL CALL HOUSE OF DELEGATES

pursuant to the Bylaws, Chapter IV, Section 1:

HOUSE OF DELEGATES Meetings scheduled

**Notice to: Delegates, Alternate Delegates, Officials
of the North Carolina Medical Society, and Presidents
and Secretaries of county medical societies.**

Sessions of the HOUSE OF DELEGATES will convene in
the Cardinal Ballroom, The Carolina, Pinehurst, North
Carolina, at the following times:

Sunday, May 19, 1974—2:00 p.m.—Opening Session

Tuesday, May 21, 1974—2:00 p.m.—Second Session

THE CREDENTIALS COMMITTEE will be present to receive dele-
gate registration for certification beginning at 1:30 p.m., Sunday,
May 19, 1974, just inside the entrance of the Cardinal Ballroom.

REFERENCE COMMITTEE HEARINGS

Reference Committee hearings are scheduled for Monday, May 20, 1974, at 2:00 p.m.

George G. Gilbert, M.D., President
James E. Davis, M.D., Speaker
E. Harvey Estes, Jr., M.D., Secretary
William N. Hilliard, Executive Director

for Continuing Education, Bowman Gray School of Medicine, Winston-Salem 27103

May 14-16

The Neuro-endocrinology Symposium: Neurobiology of CNS—Hormone Interaction
Place: UNC Student Union Building, Great Hall
Sponsors: UNC Neurobiology Program and Laboratories for Reproductive Biology
For Information: Miss Ann Francis, Administrative Assistant, Office of Continuing Education, UNC School of Medicine, Chapel Hill 27514

May 15

Ethel Nash Day Program
Place: Clinic Auditorium, Time: 1:00-5:30 p.m.
Sponsor: Department of Obstetrics and Gynecology
For Information: Miss Ann Francis, Administrative Assistant, Office of Continuing Education, UNC School of Medicine, Chapel Hill 27514

May 16-18

Basic Mechanisms in Hypertension
Place: Babcock Auditorium
Sponsor: American Heart Association Basic Science Council
For Information: Emery C. Miller, M.D., Associate Dean for Continuing Education, Bowman Gray School of Medicine, Winston-Salem 27103

May 18-22

120th Annual Session of the North Carolina Medical Society: General Session on Scientific Subjects and Specialty Section Meetings
Place: Pinehurst Hotel and Country Club
For Information: Mr. William N. Hilliard, Executive Director, P. O. Box 27167, Raleigh 27611

May 28-31

Fourth postgraduate course in Head & Neck Anatomy
Sponsors: Department of Anatomy, School of Medicine, in cooperation with the Division of Continuing Education, East Carolina University
Fee: \$125.00; students in residency programs \$75.00
Eligibility: Open to holders of any of following degrees: M.D., D.D.S., D.M.D., Ph.D.
Credit: Approved for 28 hrs. AAFP elective hours; CE units also given by Division of Continuing Education, ECU
For Information: Head & Neck Anatomy Course, ECU Division of Continuing Education, P. O. Box 2727, Greenville 27834

May 29-30

Hypertension: Critical Problems—25th Annual Meeting and Scientific Sessions, North Carolina Heart Association
Place: Hyatt House and Convention Center, Winston-Salem
Designed especially for nurses and physicians
For Information: North Carolina Heart Association, 1 Heart Circle, Chapel Hill 27514

June 12-15

Neurology for Practicing Physicians
Place: Babcock Auditorium
Sponsor: American College of Physicians
Fee: Members, residents and research fellows \$120; non-members \$175; associates \$60
For Information: Emery C. Miller, M.D., Associate Dean for Continuing Education, Bowman Gray School of Medicine, Winston-Salem 27103

June 20-22

Mountain Top Assembly
Place: Waynesville Country Club, Waynesville
For Information: R. Stuart Roberson, M.D., P. O. Box 307, Hazelwood 28738

July 29-August 2

2nd Annual Beach Workshop: Selected Topics in General Internal Medicine
Sponsors: Bowman Gray, Duke and UNC Schools of Medicine, in conjunction with the Medical University of South Carolina
Place: St. Johns Inn, Myrtle Beach, South Carolina
Fee: \$100
For Information: Emery C. Miller, M.D., Associate Dean

for Continuing Education, Bowman Gray School of Medicine, Winston-Salem 27103

Loan Materials Available

A packet of materials to help you Train Your Own Assistant is available to members on a loan basis from Med Society headquarters. It includes a color TV tape cassette practice forms for planning and evaluation, and TV evaluation report forms. For more information write: Gene Sauls, North Carolina Medical Society, P. O. 27167, Raleigh 27611.

In Contiguous States

April 2-4

Institute on Dietetic Department Administration
Place: Sheraton-Nashville Hotel, Nashville, Tennessee
Fee: \$72
For Information: American Hospital Association, 840 N. Lake Shore Drive, Chicago, Illinois 60611

April 16

Fourth Annual Charles W. Thomas Lecture
Place: George Ben Johnston Auditorium
Sponsor: Division of Connective Tissue Diseases
For Information: Department of Continuing Education, Medical College of Virginia, Box 91, MCV Station, Richmond, Virginia 23298

April 20-24

"Selection of Materials for Reconstructive Surgery," Sixth International Biomaterials Symposium
Designed to bring together clinicians in orthopedics, surgery, plastic and reconstructive surgery with leading researchers in biomaterials, biomechanics, biophysics, experimental surgery
Place: Clemson University, Clemson, South Carolina
For Information: Dr. Samuel F. Hulbert, Dean of Engineering, Tulane University, New Orleans, Louisiana 70116

May 6-9

The Treatment of Coronary Syndromes
Place: Royal Coach Motor Hotel, Atlanta, Georgia
Sponsors: American Heart Association Council on Clinical Cardiology and the Department of Medicine of Emory University School of Medicine
For Information: Miss Mary Anne McInerney, Director, Department of Continuing Education Programs, American College of Cardiology, 9650 Rockville Pike, Bethesda, Maryland 20014

Items submitted for listing should be sent to: WHEN? WHERE?, P. O. Box 8248, Durham, N. C. 27708, by the 10th of the month prior to the month in which they are to appear.

News Notes from the—

DUKE UNIVERSITY MEDICAL CENTER

The Duke Medical Center has adopted a code of dress and grooming for its employees, with particular emphasis on those who are directly involved in patient care.

The "dress code," as it is called, was designed in part to create a better professional atmosphere at Duke.

But it also is aimed at helping patients, visitors and Duke employees themselves more clearly identify physicians and other health professionals, and to

employees a greater pride in their own appearance and personal identity.

The code is part of a patient-oriented program which has been unfolding at the medical center over the past year. Other innovations include preparation and distribution to all hospital patients of a "Patient's Bill of Rights."

Also under construction now is a patient discharge unit. Patients unable to leave the hospital at normal charge time, possibly because of transportation difficulties with their families, may wait in this lounge area. This will free their beds on the ward so that incoming patients may be admitted and taken to their rooms more quickly.

The over-all program is being developed and coordinated by the Committee on Patient Services and Personnel Relations, chaired by a neurosurgeon, Dr. Richard Kramer.

* * *

Eighteen faculty members have been promoted, including Dr. Blaine S. Nashold Jr., who was promoted to a professor of neurosurgery.

Eleven have been promoted to associate professorships. They are Dr. Nels C. Anderson, physiology; Warren P. Bird, medical literature; Dr. Per-Otto Hagen, experimental surgery; Dr. Dale T. Johnson, medical psychology; Dr. William B. Kremer, medicine; Dr. Melvyn Lieberman, physiology; Dr. Stephen Mahaley, Jr., neurosurgery; Drs.

Lorne M. Mendell and Elliott Mills, physiology; Dr. David W. Schomberg, obstetrics and gynecology; and Dr. Frances K. Widmann, pathology.

Promoted to assistant professorships are Drs. J. Gordon Burch, Walter E. Davis and Peter Gebel, medicine; Dr. Richard F. Kay, anatomy; Dr. Allen David Roses, medicine; and Dr. Timothy L. Strickler, anatomy.

* * *

Dr. William J. Kane, a practicing family physician from Hamilton, N. Y., has been appointed director of the Duke-Watts Family Practice Residency Training Program to succeed Dr. Lyndon K. Jordan who resigned in September.

Kane's primary goal will be to continue to develop a sound educational program for the training of family physicians utilizing the resources at Duke, Watts and the Family Medicine Center, formerly called Durham Health Care.

He said he believes the residency program must become a viable model for the undergraduate medical students, and the program should have an important impact in the primary health care of people in the area and in the state.

The Pennsylvania native is a 1972 graduate of the University of Rochester and Highland Hospital (New York) residency program, one of the oldest in the nation for training family physicians. He received his board certification in family practice in August,

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WEIR M. TUCKER, M.D.

GEORGE S. FULTZ, JR., M.D.

GRAENUM R. SCHIFF, M.D.

1972, and he is a 1969 graduate of the Temple University School of Medicine.

* * *

The Center for the Study of Aging and Human Development has created two new posts for associate directors in a move that reflects the expanding scope of the center's programs.

Dr. George Maddox, director of the center, announced that Dr. Walter Obrist, professor of medical psychology, has been named associate director for research development and Dr. Eric Pfeiffer, professor of psychiatry and project director of Older Americans Resources and Services (OARS), has been named associate director for programs.

* * *

Dr. David C. Sabiston, chairman of the Department of Surgery, is the new editor of the *Annals of Surgery*, the nation's foremost journal of surgical science, and he also is the new president of the Southern Surgical Association.

* * *

Appointed to assistant professorships are Dr. James E. Hall, physiology; Dr. Edward W. Holmes, medicine; Dr. Robert David Nebes, medical psychology; and Dr. John L. Sullivan, psychiatry.

Hall received his B.A. degree in 1963 from Pomona College in Claremont, Calif. He obtained his M.A. and Ph.D. degrees in physics from the University of California in Riverside.

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CONTACT:

Placement Service
N. C. Society of Anesthesiologists
Department of Anesthesiology
North Carolina Memorial Hospital
Chapel Hill, North Carolina 27514

Following military service, Hall joined the Duke staff in 1970 as a postdoctoral research fellow working under Drs. Carver Mead in electrical sciences and Max Delbruck in biology.

A native of Winona, Miss., Holmes came to Duke in 1970 as a resident in medicine. He received a B.S. degree from Washington and Lee University, Lexington, Va., and M.D. from the University of Pennsylvania School of Medicine in Philadelphia.

Prior to his recent appointment, Holmes served as chief medical resident at Duke.

A 1965 graduate of Tufts University in Medford, Mass., Nebes received his Ph.D. degree in psychology at the California Institute of Technology, Pasadena in 1971.

He came to Duke in 1970 as a postdoctoral fellow in the Neurosciences Research Program and from 1971-72 served as a psychologist at the Durham Veterans Administration Hospital.

Sullivan received his A.B. degree from Duke in 1965 and his M.D. from Johns Hopkins School of Medicine in Baltimore, Md., in 1969. He served a straight medical internship at Johns Hopkins Hospital and was a resident in psychiatry at the University of California, San Diego School of Medicine in La Jolla.

Prior to his appointment at Duke, Sullivan was a course lecturer and director of the Psychopharmacology Clinic in the Department of Psychiatry at the University of California.

News Notes from the—

BOWMAN GRAY SCHOOL OF MEDICINE WAKE FOREST UNIVERSITY

Three undergraduate colleges are participating with Bowman Gray in a program through which highly qualified students may gain early acceptance into the medical school.

The participating schools are Davidson College, Wake Forest University and Swarthmore College. The program will allow qualified premedical students to be accepted by Bowman Gray at the end of the sophomore year. If the students continue to perform satisfactorily during their last two years of undergraduate work, they will be admitted to the medical school.

* * *

Dr. Maxwell M. Wintrobe, Distinguished Professor of Internal Medicine at the University of Utah Medical Center, was a visiting professor Feb. 13 at Bowman Gray.

He presented the third annual Wingate M. Johnson

Memorial Lecture. His topic was "The Inert Particle—The Story of Discovery."

The visiting professorship was established as a living memorial to the late Dr. Wingate M. Johnson, former professor of medicine at Bowman Gray.

Dr. Wintrobe is internationally prominent as a researcher and a clinician, particularly for his work in hematology.

He is a past president of the Association of American Physicians, the American Society of Hematology, and the Association of Professors of Medicine.

* * *

Four prominent North Carolinians have been appointed to the Board of Visitors of the Bowman Gray School of Medicine.

They are: Mrs. Smith Bagley, Winston-Salem housewife and civic leader; Richard T. Chatham of Hickory, president of Chatham Manufacturing Co.; W. Roger Soles of Greensboro, president of Jefferson-Pilot Corp. and Jefferson Standard Life Insurance Co.; and J. Paul Sticht of Winston-Salem, president and chief executive officer of R. J. Reynolds Industries, Inc.

* * *

Dr. Jack W. Strandhoy, assistant professor of pharmacology, has been awarded a \$10,000 grant by the Pharmaceutical Manufacturers Association Foundation.

The grant will support Dr. Strandhoy's research studies on the kidney.

Dr. Strandhoy is studying the role of prostaglandin in kidney function.

"Management of Peptic Ulcer" was the topic for the fourth annual Surgical Symposium which was held Jan. 18 at the Bowman Gray School of Medicine.

The two-day symposium featured two visiting professors and seventeen members of the Bowman Gray faculty.

The visiting professors were Dr. John L. Sawyers, professor of surgery and chief of surgical service at Vanderbilt University Medical Center, and Dr. Graham Jefferies, professor and chairman of the Department of Medicine at the Milton S. Hershey Medical Center.

* * *

Dr. Donald M. Hayes, professor and chairman of the Department of Community Medicine, recently was elected to the Board of Directors of the North Carolina Health Council.

The council is a coordinating, planning and action agency for voluntary and governmental health programs in the state.

* * *

Dr. John S. Kaufmann, assistant professor of medicine and pharmacology, is a recipient of the Pharmaceutical Manufacturers Association Foundation Faculty Development Award in the field of clinical pharmacology. He recently was elected to membership in the American Society for Clinical Pharmacology and Therapeutics.

* * *

Dr. Clark E. Vincent, professor of sociology, has been selected to serve on the editorial board of the *Journal of Sex and Marital Therapy*.

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physicians and administrative representatives of NCMPRF, Inc. in conjunction with county medical societies and hospital staffs. The intent and provisions of the PSRO law will be discussed. Recent developments in Washington and the current situation in North Carolina will be discussed. These seminars will be presented throughout the State in approximately 10-12 locations, in conjunction with various county medical societies. Plans are now be-

ing finalized as to specific dates and locations of these seminars which will be held through June 30, 1974.

The Foundation has convened a committee representing all specialty disciplines to review existing peer review methodologies and to establish norms of medical care. It will identify the process and criteria that will be most appropriate to North Carolina.

Month in Washington

The American Medical Association has branded as "wrong medically, wrong morally, and wrong legally" the Health, Education, and Welfare Department's proposed regulation requiring pre-hospital-admission certification for Medicare and Medicaid patients.

In what appeared as an ending to a "deliberate effort on the part of the AMA over the past four or five years to cooperate with HEW," the Association announced that if the pre-admission certification regulation and the Professional Standards Review Organizations area designations were placed into effect, HEW Secretary Caspar Weinberger would be taken into court.

AMA President Russell B. Roth, M.D. and Board Chairman James H. Sammons, M.D. at a press conference in Chicago made the following statement:

"We are here today to serve notice on Secretary Weinberger that if he proceeds with two proposed actions, we are going to take him to court.

"Earlier this month, the Secretary of the Department of Health, Education, and Welfare issued a set of proposed regulations that would require pre-admission certification for Medicare and Medicaid. If adopted as proposed they would require that every Medicare and Medicaid patient be cleared by a Utilization Review Committee before admission to a hospital. The only exception would be emergency cases.

"These regulations are a direct threat to the medical care of the 35 million or so patients who are served by Medicare and Medicaid. For most of them, the withholding of Medicare or Medicaid hospital benefits will mean that the individual will be denied

hospitalization because they have no other means to pay for their care.

"Furthermore, such decisions would not be made on the basis of an examination of the patient by physicians. Rather, they would be paper decisions. The verdict would be rendered on the basis of what the patient's doctor put down on the record. It is like that, as a practical matter in many instances, the decision would not be made by a committee of physicians or even a single physician but by an admitting nurse or other hospital administrative personnel.

"Any such denial of medical care represents a clear violation of both the spirit and the letter of the Medicare-Medicaid law. Congress clearly established the programs to provide medical care for the elderly and the poor. What the Congress has given, the Secretary now seeks to take away. The Secretary has no authority under the guise of regulations to amend the law and reduce benefits. He has no moral or legal right or authority to do so. Indeed, his action is illegal as it is reprehensible. The Medicare-Medicaid law provides for pre-admission certification by the patient's physician and for post-admission review by hospital utilization review committees. The Congress did not intend that a committee substitute a paper decision for the judgement of a patient's physician. The Secretary's proposal is a direct and clear violation of Section 1801 of the Medicare-Medicaid law.

"We intend to fight Mr. Weinberger on this. The proposed regulations are wrong medically, wrong morally, and wrong legally. We are here to serve notice on the Secretary that if he persists in putting

the regulations into effect, the AMA will seek an injunction on that very same day to stop him.

"We would welcome support from all interested parties, such as senior citizen organizations and consumer groups. We would hope they would join in our action. But with them or without them, we will be in court on the day those regulations are promulgated. "While we are in a suing mood, let me mention that we are also going to take on Mr. Weinberger in another area.

"This involves his gerrymandering of the PSRO district. Without getting too involved, let me say for those of you who don't know, PSRO stands for Professional Standards Review Organizations. These are supposed to be groups of doctors set up to review the quality and medical necessity of care given under Medicare and Medicaid.

"The AMA originally opposed PSRO. But once it became law, we decided that if such review was going to be done it would be better for all concerned if it were done by physicians.

"We decided to cooperate with HEW in the implementation of the law. I can tell you, we've had very little cooperation in return.

"Peer review—the concept on which PSRO is based—was invented by the medical profession and is in existence long before the government ever heard of the idea. There are many excellent and functioning peer review programs now in effect in this country, and we asked the Secretary to set up the PSRO designated areas (regional units) so as not to disturb them.

"This plea apparently fell on deaf ears. I won't hazard a guess as to the reason behind the Secretary's area designations. I don't think there were any. I think the decision was simply capricious and arbitrary.

"Our Board of Trustees has voted to join with any other state organizations who want to go to court to upset the area designation in their state. Our preliminary indications are that seven or eight may do so.

"Let me say in closing that over the past four or five years we have made a deliberate effort to cooperate with HEW in implementing government programs for the benefit of the people. I think for a while there was good communication and good cooperation.

"That day apparently has passed. Of late we've had nothing but rebuff after rebuff. We've now been left with no recourse but to fight in our own best interests and, we believe, in the best interests of our patients."

* * *

"Physician fees in 1974 have been ordered held to a four per cent increase by the Cost of Living Council. Despite strong arguments from physician groups including the AMA for an exemption from all wage and price controls for the medical profession, the Council refused to step back from its November proposal to impose the four per cent ceiling.

As in November regulations, physicians under Phase IV will be permitted an annual aggregate fee increase of four per cent. A ten per cent maximum fee increase is allowed for specific charge items; fees under \$10 can be raised by \$1.

The limits are effective as of the first of this year. They remain legally in effect until April 30 by which time Congress must authorize an extension of the President's power to impose wage-price controls or they will expire. There is growing sentiment in the Senate and the House to terminate the program.

The regulations in the health field have been under court attack. Nursing homes have won a preliminary legal battle in their suit against the Phase III controls. The American Hospital Association has threatened to challenge the controls in court.

Hospitals were restricted to a 7.5 per cent increase per in-patient stay, with adjustments for volume changes.

Under the final regulations, all physicians must maintain a schedule showing prices in effect on December 28, 1973, which comprises 90 per cent of their revenues, and the subsequent changes and dates. "A conspicuous and easily readable sign" must be posted stating the availability and location of the price schedule. The requirement applies whether or not fees have been increased.

The Council said that physicians and medical laboratories that have not raised charges as allowed in the past will be allowed to apply the unused portion of increase up to a maximum of five per cent.

* * *

President Nixon is enthusiastically endorsing the Health Maintenance Organizations program effort getting underway at the HEW Department, according to federal health officials.

The government is "going all out" to implement the new law "as rapidly as possible," Charles Edwards, M.D., Assistant HEW Secretary for Health, said.

Proposed regulations to carry out the HMO program will be issued by the end of March.

At a briefing of health reporters, Dr. Edwards announced that the director of the HMO program is Frank Seubold who has been serving as Deputy Director of the old HMO office as well as Associate Director of the Bureau of Community Health. Seubold, 51, is a Ph.D. chemist who came to HEW in 1971 after a career in the aerospace industry in California during which time he became increasingly involved in space medicine and medical systems management work.

With respect to the new HMO law that authorizes \$375 million over the next five years, Dr. Edwards said that for the first time the government is going to be making changes in the economic base of health care delivery in this country. The HMO concept attains added importance, he told reporters, as the Ad-

ministration and Congress move on national health insurance proposals.

* * *

Health outlays last fiscal year for the nation reached \$94.1 billion, an 11 per cent increase, the lowest rate in several years. The proportion of total health spending to the Gross National Product remained at the 1972 level—7.7 per cent. Per capita expenditures rose \$41 to \$441, including private and government spending.

The Social Security Administration's preliminary figures for the fiscal year that ended last July showed per capita private spending on health of \$265 and government spending of \$176 per person for the year.

The ratio of public versus private health spending continued the trend of two decades toward more government spending. The ratio for fiscal 1973 was 60.1 per cent private and 39.9 per cent public. In 1928, the corresponding ratio was 86.7 per cent and 13.3 per cent.

Of the \$94 billion total, \$36 billion went for hospital care, \$18 billion for physicians' services, compared with \$32.6 billion and \$16.6 billion the previous year.

Federal spending was estimated at \$24.6 billion, up almost \$2 billion; state and local, \$12.9 billion, up more than \$1.5 billion.

Expenses for prepayment and administration, largely private health insurance expenses, rose from \$2.4 billion in fiscal 1972 to \$3.3 billion in fiscal 1973.

* * *

The American Medical Association recognizes that supplemental printed information given to the patient by the pharmacist at the physician's discretion would be valuable for certain classes of drugs.

However, the AMA stated at a Washington, D. C., conference on patient drug information that the preparation and distribution of such informational material pose a number of problems.

"Patients differ in their drug requirements with respect to dose, duration of therapy and adjunct medication. They also differ in therapeutic response, adverse side effects and toxic reactions. The information in a 'patient package insert' might be helpful to some patients but might confuse, frighten or even harm other patients."

The meeting of medical, drug and consumers' representatives was told by an AMA spokesman that the usefulness of a patient package insert should be explored for a limited number of drugs. The AMA, the Food and Drug Administration and the manufacturers could cooperate in preparing informational material on a limited number of drugs, selected because they are used over a long period of time or have a high incidence of interaction with other drugs.

The acceptance of such material by patients and physicians and the impact it might have on the way in which patients used drugs should be assessed before encompassing a large number of therapeutic agents in the program, according to the AMA.

The FDA has been considering steps to broaden the package insert to assure it reaches patients for many drugs.

* * *

Dr. John Zapp, D.D.S., Deputy Assistant Secretary for Legislation of the HEW Department is resigning to join the Washington office of the AMA as Director of the Department of Congressional Relations.

Dr. Zapp has been at HEW since 1969. He held a variety of posts including Deputy Assistant Secretary for Health Manpower. The 41-year-old official has been involved with health legislation for several years and has served as federal representative to the AMA American Medical Colleges Liaison Committee of Medical Education.

Dr. Zapp will replace William Colley as the head of AMA's Congressional Relations Department.

Book Review

Speech and Reason: Language Disorder in Mental Disease. By Wilfred Abse, M.D., and a translation of *The Life of Speech* by Philipp Wegener. 310 pages. Price, \$12.00, Charlottesville: The University of Virginia Press, 1971.

Those of us who were fortunate enough to enjoy the collegueship of Dr. Abse, when he was Clinical Director of Dorothea Dix Hospital and later Pro-

fessor of Psychiatry at the University of North Carolina, will not be surprised to see the publication of this scholarly work. Wilfred Abse has always brought an intense interest in psychoanalytic formulation and a broad knowledge of language and literature to bear on his clinical studies of patients. His own skills as a gifted speaker and writer are matched with a special fascination in man's capacity, or incapacity, for com-

unication. In particular, Abse is intrigued by the figures of speech which are used in communication, and his earlier writings on hysteria and other topics have illustrated this as well as his own capacity to use the English language elegantly.

Abse points out that the study of language is necessarily grounded in social psychology. As a student of Freud's works, with all their contributions to language theory, he is impressed with the fact that a contemporary of Freud, Philipp Wegener, shared many ideas with the founder of psychoanalysis. Whether or not Freud and Wegener knew each other's work is unknown. Abse illustrates the value of Wegener's ideas in the elucidation of problems of hysteria. A chapter on hysteria and metaphor touches on medical and psychoanalytic history and illustrates with clinical material how metaphoric statements convey affective communication. Thus, the metaphor cannot be perceived merely as having an ornamental function. The book proceeds to discuss enunciation and metaphor, thought, imagery, symbolism, dreams, schizophrenia and development of language in a series of interwoven and carefully constructed chapters.

All of the above described writing contains much original scholarship as well as a constructive review and synthesis of other experts. Abse presents this edition of the book as an introduction to the first English translation of Wegener's *The Life of Speech* originally published in 1885. Although this reviewer found the latter of interest, he obtained the greater intellectual stimulation from Abse's own original contribution. This is perhaps understandable in that a psychiatrist with Abse's gifts is bound to appeal to a fellow professional.

The second half of this book undoubtedly fills a

need, and many professional groups are well served with this translation with which Abse obtained competent scholarly assistance within the University of Virginia, where he is now Professor of Psychiatry. I found Wegener's work interesting but the flow of reading was interrupted by the frequent parenthetical insertions of the original German phrases. However, no doubt these insertions may be valuable for the linguistics expert who is seeking some fine point of nuance. Wegener perceives words as being first learned as a means to achieve definite ends. Thus the child starts communicating with one-word sentences, for example with the word "milk" meaning "give me some milk." Thereafter, language develops into more complex forms through the processes of emendation and metaphorical extension. Syntactical forms of speech arise from emendation whereas abstract reference and generality come from metaphorical extension. Indeed, abstract language, according to Wegener, is "faded metaphor."

Abse shows how the metaphor can carry such an impact because of its unconscious associations. He also demonstrates how in psychopathology the metaphor can become a physical symptom. Thus, this whole volume has something of significance for a wide spectrum of professionals ranging from the psychologist, psychiatrist and behavioral scientist to the communication theorist and language expert. As Abse points out, many of today's political and social problems are compounded by the lack of effective communication. Thus, this scholarly study of language, communication, and thinking is pertinent to the understanding of normal man as well as the psychiatrically disturbed.

JOHN A. EWING, M.D.

In Memoriam

Eugene Ramsey Hardin, M.D.

We are meeting once more to pay a tribute of respect to the memory of one of our comrades, who, marching through the span of years has fallen by the wayside and now sleeps the everlasting sleep. He is Eugene Ramsey Hardin, pioneer physician and noted public health official, who passed away November 18, 1973 after a short illness.

It is a fundamental fact that we are born to die, but in the plan and providence of God the opportunity is given every man to so live in service to, and

fellowship with, his comrades that the memory of his good deeds will follow him long after the dark portals of the grave have claimed their own.

Dr. Hardin was born in Appling, Georgia on December 6, 1888. He graduated from Harlem High School in 1905 and attended Sacred Heart College from 1905 to 1907. In 1911 he received his M.D. degree from the University of Georgia Medical School. He served as an intern in Lamar General Hospital, Augusta, Georgia. At the end of this service he was appointed intern in Wilard Parker Hos-

pital, the largest contagious disease hospital in New York City.

In 1915 he accepted the position of Health Officer of Sampson County, N. C. From August 1917 to August 1919 he served with the Army Medical Corps, and on September 1, 1919 he began his work as Health Officer for Robeson County.

During his career he received many honors and achieved many goals. Dr. Hardin's interest in public health work was keen, tireless, and constructive. He kept in close touch with advancing public health thoughts and practices. He was always alert to what medical organizations, especially those in his own state, were saying and thinking about public health work. In legislative years it was his custom to observe and work for pending legislation concerning improved public health laws.

Upon his retirement in 1969, after 50 years as head of the oldest rural county health department in the nation, he was praised at a testimonial dinner for his unselfish work in making Robeson County a better and safer place to live. Dr. Hardin once said, "I have always felt that next to religion, public health is the most important service one can give his fellow man."

Resolved, that this resolution and a copy be incorporated in the minutes of the Robeson County Medical Society, a copy be mailed to each member of the bereaved family, a copy be sent to *The Robesonian*, and the NORTH CAROLINA MEDICAL JOURNAL.

ROBESON COUNTY MEDICAL SOCIETY

The internal use of water, as a medicine, is no less an object of the physician's attention than the external. Pure elementary water is, indeed, the most inoffensive of all liquors, and constitutes a principal part of the food of every animal. But this element is often impregnated with substances of a very active and penetrating nature; and of such an insidious quality, that, while they promote certain secretions, and even alleviate some disagreeable symptoms, they weaken the powers of life, undermine the constitution, and lay the foundation of worse diseases than those which they were employed to remove. Of this, every practitioner must have seen instances; and physicians of eminence have more than once declared, that they have known more diseases occasioned than removed by the use of mineral waters. This doubtless, has proceeded from the abuse of these powerful medicines, which evinces the necessity of using them with caution.—*William Buchan: Domestic Medicine, or a Treatise on the Prevention and Cure of Diseases by Regimen and Simple Medicines, etc., Richard Folwell, 1799, p. 430.*

NORTH CAROLINA

Medical Journal

THIS ISSUE: Poisons that Killed: An Analysis of 300 Cases, Abdullah Fatteh, M.D., Ph.D., LL.B., and Bill Hayes, B.S.; The Role of Gastroesophageal Reflux in Nocturnal Asthma in Children, Susan C. Dees, M.D.; Need for More and Better Distributed Primary Care Physicians in North Carolina, Committee on Community Medical Care, North Carolina Medical Society

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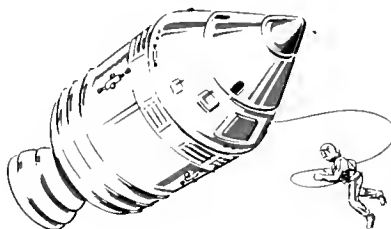
Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive dis-

orders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant

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PRESIDENT'S NEWSLETTER

MEDICAL SOCIETY OF THE STATE OF NORTH CAROLINA

o. 11

April 5, 1974

PSRO -- It would be nice to have one month pass without necessary bulletins as to PSRO. It is even certain that by the time this reaches you, more events will have transpired than have as of this writing. Even though the major action of PSRO in this state will be centered with the Peer Review Foundation which is a separate entity from the Medical Society, it still involves all of us. The recent gross developments are as follows:

1. Having lost our battle for a single statewide PSRO, the final area designations were published in the FEDERAL REGISTER March 18. At least they followed the recommendations of our Peer Review Foundation for realistic and logical "patient flow" areas as compared to the original capricious four that were suggested by HEW. We end up with eight areas and the boundaries may be obtained either from our Headquarters Office or the Peer Review Foundation office which now has a separate space in our Headquarters Building. The number of hospitals in each area varies from eight to twenty-seven and the number of physicians from 363 to 1,012.
2. Well, you ask, what comes next? Now, HEW announces that they are ready to receive applications from organizations (formed by HEW guidelines) in each PSRO area. Two types of applications may be submitted: (1) "planning contracts" and (2) "conditional designation contracts". Outside of each individual PSRO area, a third type of contract called "statewide PSRO support center contracts" may be filed. So, as far as we are concerned, our North Carolina Peer Review Foundation is eligible for the last type and it is applying to HEW to be so designated. However, obviously none of our eight areas have had time to get together and form a professional association, be legally incorporated as a non-profit organization as they require, and then submit a plan for a formal peer review system under HEW guidelines. Now believe it or not, these bureaucratic bunglers have set a deadline for all applications from every PSRO area to be submitted by April 15th for planning contracts and April 30th for the conditional designation contract type.
3. Well, what else you ask? Within a proper amount of time to be prepared and practical and despite "the bunglers," our Peer Review Foundation will be getting to you with all the detailed help possible and as soon as possible. This effort is being financed by the North Carolina Regional Medical Program to the tune of over \$50,000.
4. In the meantime and involving very intense concentrated activity all over the country, I'd simply report that the rebellion against PSRO is growing as is congressional awareness of the movement. The rebellion is taking two forms: (1) an all out fight for repeal (recently adopted as policy by both the Illinois and Georgia Medical Societies) and (2) introduction of eleven carefully thought out major amendments of the law which the AMA

has proposed for congressional action. Needless to say, our own House of Delegates will be reassessing our own position at our May meeting.

C.O.L.C. -- Now for some good news! By action last week of the Senate Banking Committee, it appears that the Cost of Living Council will be phased out as of April 30th. Should this come to pass, a colossal sigh of relief will come from the entire health field. Wonderful as is this outlook, let me be one of the first to warn you, with your newly returned freedom, don't go wild with your fee increases. Be reasonable, because our bureaucratic enemies of the private practice of medicine like nothing better than to throw high medical fee statistics at us.

POLITICS -- As you well know, there is a strong sentiment in the wake of Watergate to throw out all of the "so and sos" in Washington. Cynical as we have every reason to be, we must get down to intense, practical politics for the upcoming congressional and senatorial primaries and the fall election. Whomever we vote into office will determine what type of national health insurance we may have along with all our other concerns. So, evaluate your candidate, find out where he stands, and if he is with us not only support him personally but also through your membership in the North Carolina Political Action Committee.

MEMBERSHIP SURVEY -- By the time you receive this newsletter, you will have already gotten in the mail a survey postcard asking for your help and advice on whether you would prefer to continue holding the Annual State Medical Society Meeting in May or hold it in September. You are also being asked to indicate a preference for towns which now appear to have adequate facilities for holding the Annual Meeting, along with any other meeting suggestions you may care to make. We need your opinion, so please complete and return the card promptly to the Medical Society Headquarters. This is but one of the ways in which the Officers and Staff of the Society are trying to provide the kind of Annual Meeting you and the other members most desire.

PRESIDENT'S NEWSLETTER -- In the future, after the April issue, a duplication of the President's Newsletter will not appear in the North Carolina Medical Journal. This action is being taken in the interest of economy and wisest possible use of your membership dues dollars.

DRUG AUTHORITY -- I'll close with another pleasant note. Many of you have responded to requested data for the North Carolina Drug Authority and their analysis of drug abuse in this state. Mr. F. E. Epps, the Director, with Mr. Moody B. Drum have requested that I pass on their thanks for your contributions which have been most helpful.

Hold on to your hats until the next time!

Sincerely yours,



George G. Gilbert, M.D.
President

Poisons That Killed: An Analysis of 300 Cases

Abdullah Fatteh, M.D., Ph.D., LL.B. and Bill Hayes, B.S.*

IN 1969 a total of 44,864 people died in North Carolina; of these deaths, 177 were caused by poisoning agents.¹ A study of deaths resulting from poisons in North Carolina had not been undertaken in recent years. Therefore, it seemed appropriate to carry out such a study. The purpose of this study is to analyze 300 cases of poisoning in North Carolina in 1970 and to determine the distribution of poisoning cases in different age, sex, and race groups and to recognize the frequency of deaths caused by various agents. We hope that the analysis will help to suggest the means to reduce the number of deaths from poisoning, especially the number of accidental deaths.

MATERIAL AND ANALYSIS

We made a random selection of 300 cases of poisoning that occurred in North Carolina in 1970. The selections included only the cases investigated by the Office of the Chief Medical Examiner in the counties where the Medical Examiner system

was operative. The information on the cases was obtained from the case files maintained in the Office of the Chief Medical Examiner in Chapel Hill. Only the cases clearly thought to be deaths from poisoning were included. Borderline cases were excluded. Of the 300 cases studied, evidence of poisoning in 267 cases was confirmed by toxicological studies. In the remaining 33 cases the overwhelming circumstantial and investigative evidence of poisoning justified inclusion of the cases in this study.

Table 1 shows the distribution of 273 of the cases with respect to the fatal agents. In addition, single fatalities were caused by each of the following 17 single agents: strychnine, imipramine (Tofranil®) kerosene, sulphuric acid, furniture polish, varnish remover, ethylene glycol (antifreeze), paraldehyde, pentazocine (Talwin®), chlorprothixene (Taractan®), ethchlorvynol (Placidyl®), methapyrilene (Sominex), ethylene di-bromide (Fumi-sol), bromide, alkali (Plunge), zinc, and phosphate. Ten single deaths were caused by each of the following combinations: glutethimide (Doriden®) and thioridazine hydrochloride (Mellaril®); chlorpheniramine (Coricidin®) and paraldehyde; doxepin hydrochloride (Sinequan®) and alco-

hol; propoxyphene (Darvon®) and meprobamate; propoxyphene and barbiturate; morphine and phenothiazine; paraldehyde and thioridazine hydrochloride; barbiturate and chlordiazepoxide hydrochloride (Librium®); carbon monoxide with alcohol and barbiturate; and morphine with codeine and glutethimide.

Of the 134 cases of alcohol poisoning, 122 were caused by ethanol intake alone and six were caused by the other volatiles of which isopropyl alcohol, N-propyl alcohol, and methanol were a few. Six more

Table 1
Distribution of Cases with Reference to Fatal Agents

Fatal Agent	Number of Deaths
Alcohol and/or other volatiles	134
Carbon monoxide	51
Barbiturates	32
Morphine	21
	(2 more in combination with other drugs)
Arsenic	10
Salicylates	8
Meprobamate	2
Darvon	3
Digitalis	2
Lead	2
Parathion	2
Mellaril	2
Ammonia	2
Freon	2

*From the Office of the Chief Medical Examiner and East Carolina University Medical School, Greenville, North Carolina (Dr. Fatteh) and the University of North Carolina Medical School, Chapel Hill, North Carolina (Mr. Hayes).
Medical student.
Print requests to Dr. Fatteh, Professor of Pathology, East Carolina University, Greenville, North Carolina 27834.

cases resulted from a combination of ethanol and other volatiles. In the 32 cases of barbiturate poisoning, there were nine cases in which a significant level of alcohol was also found. In view of the fatal concentrations of barbiturates, these were classified as barbiturate deaths. Similarly, in two cases of morphine poisoning and in eight cases of carbon monoxide deaths, alcohol was present, although alcohol was not the primary cause of death.

In the cases studied, 218 were men and 82 were women. There were 188 Caucasians, 109 Negroes, and three Indians. The age distribution of the cases can be found in Table 2.

Table 2
Distribution of Cases with Reference to Age

Age in Years	Number of Deaths
Under 10	5
11-20	30
21-30	40
31-40	54
41-50	82
Over 50	79
Unknown	10
Total	300

Deaths from poisoning were either accidents, suicides, or homicides. We were unable to determine whether 26 deaths from poisoning were accidental, suicidal, or homicidal. Hence, the manner of death in these cases was carried as "undetermined." In the group of 300 cases, 202 (67 percent) were accidental deaths, 69 (23 percent) were suicides, and three (one percent) were homicides. In the three homicides the fatal agent was arsenic.

DISCUSSION

It is clear from the analysis of the sample that alcohol is a leading killer among all poisons; 44.7 percent of all poisoning deaths were caused by alcohol. The figures for the previous years show that in North Carolina 17 people died of acute alcohol poisoning in 1968; 21 people died of acute alcohol poisoning in 1969.² By comparison, these figures are much lower than the

1970 figure. In the past, and in certain parts of the state at present, the designations of the cause of death in persons with fatal concentrations of alcohol have been varied. Many a case has been signed out as a natural death. There is a great variation in the willingness to accept acute alcohol poisoning per se as a valid cause of death. It would appear, therefore, that the figures for the years 1968 and 1969 are gross underestimates. The 1970 figure does not necessarily reflect a true increase in the incidence of deaths from alcohol. We feel that the efforts of the Office of the Chief Medical Examiner, in the direction of better investigation and accurate labeling of the cause of death in such cases, is the factor contributing to the apparent increase in the incidence of such deaths.

Nearly all deaths from acute alcohol poisoning are accidental. Many people are not aware that alcohol in excess is poisonous and can kill. We hope that this study will serve not only to crystallize the fact that many people die accidentally from alcohol poisoning, but also that it will have some impact on the incidence of deaths from alcohol poisoning.

It appears that alcohol kills primarily the middle-aged and the elderly. In this study, 90 percent of the deaths from alcohol poisoning occurred in people over the age of 30, many of whom were chronic alcoholics. Thirty-eight percent of deaths occurred in the 41- to 50-year-old age group. In our sample, deaths from alcohol in men outnumbered those in women 3:1.

Inhalation of carbon monoxide results in the loss of several lives each year. This gas caused 51 deaths in the group under study. A surprisingly high proportion of these, 25 of 51, were accidental deaths, the remaining 26 being suicides. In two cases the manner of death was unknown. It must be stressed that most accidental deaths from the inhalation of carbon monoxide are preventable. For instance, 16 of the 25 accidental deaths occurred in automobiles which had improper ventilation or faulty exhaust systems, or

both. An awareness of the danger of such situations could reduce, not eliminate, these tragedies.

Barbiturates continue to be widely used as suicidal agents, as can be seen in the present series. Twenty-two of the 32 deaths were suicide; the manner of death in eight of the remaining ten cases being "undetermined." Only two of the deaths were accidental; these were the results of the combined use of barbiturates and alcohol.

Morphine deaths occurred in a narrow subset of the population. Of the 23 deaths attributed to morphine, two were in combination with alcohol. The remaining 21 deaths were caused by morphine alone. All were men; 21 were between the ages of 16 and 31. Of the 23 deaths attributed to morphine, 21 of the victims were Negroes. Most of the victims appeared to be addicts, as indicated by their histories or by the presence of old, as well as fresh, needle marks on their bodies. Many times needles were found in the veins or near the bodies, and other items such as syringes, tourniquets, bottle caps, and spoons were found in the victims' possession. The evidence in all cases indicated that these deaths were accidental. In North Carolina no deaths from morphine poisoning were reported in 1968 and only one death attributed to it is known to have occurred in 1969.² Therefore, the dramatic increase in the number of fatalities from morphine in 1970 should be cause for concern.

Only three deaths from arsenic poisoning were reported in 1968 in North Carolina and four were reported in 1969.² The occurrence of ten cases of arsenic poisoning in a group of 300 poisonings reflects an increase in the incidence. Even though arsenic is an age-old poison and one that is easily detectable long after death, it appears to be in fashion again as a homicidal agent. The increase in the cases of arsenic poisoning may be partially an apparent increase owing to improved investigation and detection of such cases as a result of the introduction of the medical ex-

er system. Accidental and suicidal deaths may not pose a significant problem in the investigation and detection of deaths from arsenic poisoning. However, the examiner could have a high index of suspicion to detect homicides from arsenic poisoning.

In the consideration of prevention of deaths from poisoning, suicides are a very complex problem, and the best preventive efforts may yield only barely recognizable results. On the other hand, the prevention of accidental deaths is much easier. The figures in this study, showing that over two-thirds of the cases were accidental, reflect a need for action. A large number of these accidental deaths were caused by excessive use of alcohol and inhalation of carbon monoxide. The prevention of such deaths can be accomplished, to a

degree, through education of the public. The problem of accidental deaths appears to be of great significance in North Carolina. In this state the ratio of accidents to suicides, as reflected in the analysis, is 3:1, whereas the national figures for 1966 and 1967 show that suicidal poisonings outnumbered accidents almost 2:1.^{3, 4}

SUMMARY

An analysis of 300 fatalities from poisons in North Carolina in 1970, with respect to age, sex, race, and fatal agents is presented. The significant facts that emerged are that alcohol is a leading killer and that deaths from drug addiction are on the increase. It is suggested that the increase in the incidence of deaths from alcohol, arsenic, and drugs of addiction may be partially an appar-

ent increase, owing to better methods of investigation resulting from the expanding functions of the medical examiner system. The salient features that became clear from this study are the high incidence of accidental deaths from poisoning in this state and the importance of the prevention of deaths resulting from poisons.

ACKNOWLEDGMENTS

The authors wish to extend sincere thanks to Dr. Page Hudson and Dr. Arthur McBay for their advice and cooperation.

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2. Tessenear, C.: Personal communication, 1970; Office of Vital Statistics, State of North Carolina.
3. Vital Statistics of the US, 1967, Vol II-Mortality, pp 84-86, Part A, Section 1, US Public Health Service, US Department of Health, Education, and Welfare.
4. Vital Statistics of the US, 1966, Vol II-Mortality, pp 82-86, Part A, Section 1, US Public Health Service, US Department of Health, Education, and Welfare.

I would not only caution patients who drink the purging mineral waters overnight to avoid heavy suppers, but also from eating heavy meals at any time. The stimulus of water, impregnated with salts, seems to create a false appetite. I have seen a delicate person, after drinking the Harrowgate waters of a morning, eat a breakfast sufficient to have served two ploughmen, devour a plentiful dinner of flesh and fish, and, to crown all, eat such a supper as might have satisfied a hungry porter.—William Buchan: *Domestic Medicine, or a Treatise on the Prevention and Cure of Diseases by Regimen and Simple Medicines, etc.*, Richard Folwell, 1799, p. 432.

The Role of Gastroesophageal Reflux in Nocturnal Asthma in Children

Susan C. Dees, M.D.

ALL of us who treat patients having asthma are familiar with the repeated complaints that the asthmatic attacks are more severe at night than in the daytime and that the attacks are often preceded by severe bouts of coughing which suddenly awaken the patient from sleep.¹ Several explanations have been offered as to why these nocturnal attacks occur. It has been suggested that when the patient lies down, the vital capacity and chest mobility are reduced sufficiently to impede normal air exchange, particularly in a patient whose pulmonary function may be already slightly reduced; thus dyspnea, hypoventilation, and asthma result.² It is further suggested that secretions accumulate more readily in the respiratory tree when the patient is in the horizontal, supine, or prone position than when he is upright; therefore, in sleep, especially deep sleep, the patient, being unaware of the secretions, clears his airway less often or less effectively. Experience with problems of bronchial toilet in unconscious or paralyzed patients

has been used to substantiate this theory.³

Other investigators have suggested that the vagotonia induced by sleep may be sufficient to cause an increase in airway constriction.^{4, 5} Excessive fatigue is sometimes responsible for asthma. Some observers feel that dreams may serve as unconscious trigger mechanisms for asthma.⁶

It has been proposed that the intimate contact with the most prolific source of house and feather dust and mold in bedroom furnishings is the key to nighttime asthma. The cool, damp evening air, a sudden fall in temperature, or a rise in humidity can induce bronchoconstriction under experimental conditions and possibly contributes to nighttime asthma attacks. For the pollen-sensitive patient, the shower of pollen fall-out shortly before dawn may be the extra challenge needed to produce symptoms. In other patients, the nighttime symptoms may represent merely a longer reaction time to an allergen contact which occurred a few hours before the attack—possibly a reaction to some food taken at the evening meal.⁷

Another possible cause for nocturnal asthma is a gastroesophageal reflux in the presence of an overreactive airway. After eating a full or

partial meal, many people have gastroesophageal reflux when they are lying down, bending, or sitting. Patients with hiatal hernia frequently have reflux of stomach contents; they are prone to aspirate and have recurrent pneumonia and bronchitis.⁸ For many years thoracic surgeons have suggested that reflux may occur without hiatal hernia and may cause this same type of pulmonary disease.⁹

Whether nocturnal asthma in this setting is a result of aspiration of the stomach contents, momentary change in intrathoracic pressure secondary to reflux, stretching and distention of the esophagus, or vagal stimulation has not been established. Belsey,¹⁰ Kennedy,¹¹ Overholser,¹² Klotz,¹³ and others have reported that nocturnal asthma frequently occurs in persons who have this variation from the usual esophageal function. Without invoking possible mechanisms relating to gastroesophageal reflux, previous generations of physicians customarily advised their asthmatic patients frequently to eat small meals and to go to bed soon after eating a meal.¹⁴ Indeed, many asthmatics have discovered for themselves that this schedule for eating is helpful in procuring an untroubled night's sleep.

Read before the Pediatrics Section, North Carolina Medical Society, May 22, 1973, Pinehurst, North Carolina.

From the Department of Pediatrics, Duke University Medical Center, Durham, North Carolina 27710.

Using the so-called water siphon, for several years we have done a roentgenographic study of the esophagus and stomach of asthmatic patients. This study was carried out by means of documenting the tendency to gastroesophageal reflux in asthmatics whose symptoms were nocturnal asthma, paroxysms of coughing, or recurrent pneumonitis, bronchitis, or atelectasis suggested that more than the usual defenses might be trigger mechanisms. The water siphon test was proposed by de Carvalho¹⁵ (51) who, at the completion of a conventional barium gastrointestinal study, instructed the patient, while in the supine position, to drink 100 to 150 ml of water and to roll to the left at approximately 45 degrees. The water clears the esophagus of barium; if reflux is present, the barium erupts back up the esophagus often as high as, or higher than, the aortic arch.

Insman¹⁶ describes a positive test as one in which, after the patient has drunk the water, there is a momentary delay, then a brief peaking of the barium-filled fundus of the stomach and a dramatic clearing of the lower esophagus, often above the aortic arch. Rolling the patient slightly backward and forward, and having the patient breathe deeply, also help to stimulate reflux.

In 1,000 consecutive upper gastrointestinal studies, 40.5 percent of all patients showed reflux. A total of nine percent of the entire study had demonstrable hiatal hernia; of these, 79 percent had reflux. In patients' ages ranged from one to over 80 years; the greatest incidence of reflux was in patients who were between the ages of 41 and 71. In all patients who had hiatal hernia, it could be made to reflux. The basis of this study was exclusively on the technique and the gastrointestinal tract; no mention was made of associated pulmonary symptoms in these patients.

In a similar study by Crummy,¹⁷ only 15 to 30 ml of water, produced results similar to those of Insman¹⁶; ten percent of the patients who were examined had reflux

and 69.6 percent of those patients having pyrosis had reflux.

Our observations of patients who were selected from an asthmatic population have been sporadic. Therefore, the frequent finding of reflux does not indicate its true incidence or significance in either asthmatics in general or in normal children. Because reflux commonly occurs at all ages, it is considered a "normal" event. Dr. Arvin Robinson of the Duke University Medical Center Radiology Department is doing a systematic review of reflux in children with asthma, and other chronic chest diseases; his study includes, too, those children without chest disease who are having gastrointestinal radiography for digestive problems. The study should soon give us a more realistic idea of the incidence of reflux in patients who have chest disease and in those who do not. Robinson's preliminary figures show 17 of 30 asthmatics who have reflux, in contrast to one of 16 children who have gastrointestinal complaints.

Regardless of whether gastroesophageal reflux is a common physiologic phenomenon, our notable examples of impressive reflux seem to be associated with several recognizable patterns of nocturnal asthma. The child, in most instances, eats bedtime snacks, large or late dinners, or takes large amounts of liquid with the evening meal or before going to bed. A child who goes to bed seemingly well or with very little respiratory difficulty often has attacks that occur with clocklike regularity, night after night. In the most frequently occurring pattern, the attack begins one to two hours after the patient has lain down, and it is ushered in by sudden paroxysmal coughing and wheezing. In a less frequently occurring pattern, the attacks begin at midnight and last until 4:00 a.m. In yet another pattern, the attack begins when the patient arises in the morning, usually while he is dressing. Body positions which often elicit reflux are sudden bending, stooping, or straining. Frequently, the nocturnal attacks are much more severe than those the

child has during the daytime hours. Each child is likely to have his own stereotyped pattern of reactions.

Those children who have demonstrable reflux often have repeated episodes of severe resistant pneumonia, bronchitis, or atelectasis. We have not been able to elicit many gastrointestinal complaints from these patients, in contrast to adults in these instances, since children seldom describe "heartburn" or substernal burning. Very few were persistent vomiters, and few had anemia or malnutrition which is seen in patients who have hiatal hernia; rarely did we find hiatal hernia in any of these children. Parents have volunteered that they or other family members have hiatal hernias for which they have been using the medical program. We have not been able to ascertain whether there is a developmental or hereditary relationship between gastroesophageal reflux and hiatal hernia, but this point might bear systematic study.

None of our patients with reflux has had surgical correction of the condition. Belsey,¹⁸ Nissen,¹⁹ Vos,²⁰ and Davis and Fugate²¹ have reported successful results in children who had severe respiratory disease and reflux. The objective of the surgery is to restore competence to the lower esophageal sphincter as a valve. The surgery is accomplished by a plicating procedure, either transthoracically (Belsey)¹⁸ or by the intraabdominal approach (Nissen),¹⁹ restoring the angle of His but preserving the integrity of the vagus nerve.

We have used the simple medical program of elevating the head of the bed on six- to eight-inch blocks, restricting fluid intake to less than four ounces at a light evening meal, and prohibiting food and fluid intake after the evening meal. We have recommended that the evening meal be taken at least three hours before the patient retires. We have not recommended antacids for these children, although antacids have been advised for patients who have pyrosis or esophagitis. Some of the following case reports bear testimony to the almost immediate cessation of

nocturnal symptoms when food intake is restricted and the bed is elevated. This medical program has been effective even when the patients' symptoms have persisted for several years.

CASE REPORTS

Case 1

A girl who had a small sliding hiatal hernia and a history of severe episodes of nocturnal coughing and alarming asthma was admitted to the hospital for study several years ago. After admission, she had an episode of respiratory and cardiac arrest during her typical, nocturnal cough-asthma attack, from which she was successfully resuscitated. Since her hospitalization, the medical program to prevent reflux has controlled her nocturnal symptoms.

Case 2

Another child, aged seven, had to be taken, as often as four or five times a week, to her local hospital emergency room for the treatment of severe asthma. For months these visits were made prior to the discovery of significant reflux to the cervical esophagus. From the first night after the patient's bed was elevated and the fluid intake was restricted, she slept through the night without coughing or asthma; before any other treatment was instituted, her sleep was undisturbed for the first time in months. In the ten months that she has adhered to the medical program to prevent reflux, the patient has had only three or four nocturnal attacks, all of which, in retrospect, could be attributed to nocturnal dietary indiscretions. Since she has taken the usual environmental precautions, the patient's daytime and seasonal allergic symptoms have improved, although to a less dramatic degree.

Case 3

A seven-year-old boy who had multiple allergies gave a similar history of severe nocturnal asthma attacks. He enjoyed relative freedom from attacks during the daytime, except for sporadic attacks during several days of the pollen season or after he was exposed to animals.

This case serves as an illustration

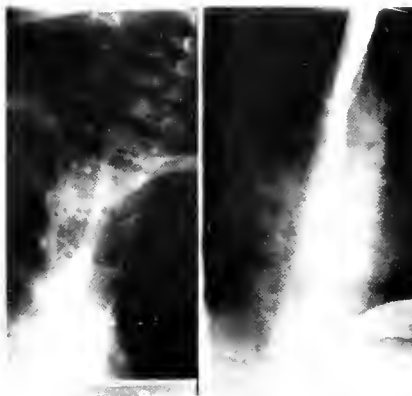


Fig. 1a. Initial barium swallow of water siphon test.



Fig. 1b. Reflux after drinking water reclining position. Barium reflux thoracic outlet.

that the water siphon test does not always indicate reflux. One year ago, the results of a water siphon test were negative after a small amount of barium was administered to the patient when his stomach was empty. However, considering the child's history of nocturnal asthma and his recent, nearly fatal episode of status asthmaticus which began abruptly several hours after he went to bed, we strongly suspected aspiration as a possible trigger for attacks. The water siphon test, repeated while the patient had a full stomach, showed massive reflux (Figures 1a and 1b).

Several authors have reported on the variability in the test re-

sponse.^{22, 23} The first patient cited in this paper had a repeat routine gastrointestinal series done four days after the first study; the hiatal hernia was not demonstrated. This variability underscores the point that a physician should not rule out possible reflux in the presence of negative results from radiologic studies, particularly when the patient's history strongly suggests reflux.

Case 4

An infant had vomiting, recurrent pneumonia, wheezing, and esophagitis. He also had a hiatal hernia which was successfully repaired recently. The infant has progressed well since surgery, although he



Fig. 2a. Hiatal hernia, esophagitis and recurrent pneumonia. Chest showing infiltrate in right middle lobe and at left hilum. Increased density behind the heart caused by esophagus distended with food.



Fig. 2b. Barium swallow postoperative pair of diaphragmatic hernia showing strictured lower esophagus and partially filled stomach.

istent lower esophageal stenosis secondary to esophagitis (Figures 1 and 2b).

The literature provides descriptions of various tests that evaluate gastroesophageal reflux and amplify roentgenographic studies. The following specialized diagnostic tests are used by gastroenterologists and surgeons: esophagoscopy; comparative measurements of pH of the esophagus, and at the lower esophageal sphincter, just within the cardia of the stomach; measurements of intra-esophageal gastric pressure at these sites²⁴; perfusion of the esophagus with one-tenth normal HCl to reproduce symptoms of pyrosis; and, radiography after the patient has swallowed neutral and acid gum.²⁵ Obviously, these tests are far more readily applied to adults and older children than to uncooperative infants or young children. We have not done any of the ongoing studies to evaluate gastroesophageal reflux in our patients. In most instances, when the setting of nocturnal asthma suggests gastroesophageal reflux, the physician is justified in instituting the medical program for the control of reflux, as a therapeutic trial, having not only the radiologic barium siphon test. In our preoccupa-

tion with the newest specific pharmacologic agents and immunotherapy for asthma, we often neglect simple hygienic measures, familiar to previous generations of physicians, which can greatly diminish symptoms and make our patients more comfortable.

SUMMARY

Gastroesophageal reflux, among various other causes, may serve as a trigger mechanism for nocturnal asthma. A characteristic history of sudden onset of nocturnal attacks is usually elicited from patients in whom reflux is present. In many instances reflux of gastric contents is demonstrable by barium water siphon roentgenography of the esophagus.

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When I speak of drinking a glass of the water over night, I must beg leave to caution those who follow this plan against eating heavy suppers. The late Dr. Daultry of New York, who was the first that brought the Harrowgate waters into repute, used to advise his patients to drink a glass before they went to bed; the consequence of which was, that having eat a flesh supper, and the water operating in the night, they were often tormented with gripes, and obliged to call for medical assistance.—William Buchan: Domestic Medicine, or a Treatise on the Prevention and Cure of Diseases by Regimen and Simple Medicines, etc., Richard Folwell, 1799, p. 431.

Need for More and Better Distributed Primary Care Physicians in North Carolina

Committee on Community Medical Care, North Carolina Medical Society

THE North Carolina Medical Society is vitally concerned with every aspect of the medical care of the people of North Carolina. Of particular concern are the deficiencies in the delivery of primary medical care to the people of North Carolina in rural and less urbanized areas of the state.¹

In keeping with the leadership that has become expected of the North Carolina Medical Society and as evidence that our present medical care system is concerned and responsive, the following position paper has been prepared on the need for more and better distributed primary care physicians. The Committee on Community Medical Care is comprised predominantly of primary care physicians who, by interest and practice characteristics, are knowledgeable of the problems involved.

PROBLEM DESCRIPTION

Distribution

It is desirable that physician services in North Carolina be evenly accessible to the population in all geographic settings in relation to demand. Until now, such accessibility has not been possible because physician distribution, as that of many

segments of the population, has been markedly influenced by economic and social conditions and by urban and rural dynamics. Such factors include the prevalence of poverty, age, and accidents, and the availability of communication, transportation, educational, cultural, and recreational resources.² The result has been a dramatically disproportionate concentration of physicians in various population areas.

Primary medical care

Of equal importance is the problem of having the right physician in the right place at the right time. The distribution of physicians by medical specialty is comparable in importance to the total number of physicians and their geographic distribution.

Health care manpower is a special and acute problem in North Carolina, particularly with respect to primary care which includes the full spectrum of basic services needed to maintain and restore health. Primary care services are called for in 80 to 90 percent of all patient needs. Yet the predominance of the effort is focused on the other 10 to 20 percent — training specialists and subspecialists who are increasingly less trained for handling the problems of primary care.²

The modern personal physician

considers the expanded health team and diverse community sources as an extension of himself. This type of team can be the most efficient and flexible means of assuring comprehensive primary health care made available to the rich and poor in rural or urban settings.²

Part of the dilemma of underserved areas is that there has not been an advocate with responsibility for allocating health care manpower for primary and rural health care. Until recently medical schools have not been accountable for producing the numbers and kinds of physicians that society needs. The types of educational programs offered have led to a migration of medical manpower from rural areas to more urban areas where the more sophisticated facilities have been located. These efforts, quite understandably, have been directed toward developing programs that would attract federal monies available at the time when, unfortunately, were mostly earmarked, until recently, through government designation for other than primary care services.²

Financing rural care is a most difficult problem. Actual cost per unit of service is frequently higher in rural areas, especially if an attempt is made to provide a broad spectrum of health care. Many rural areas are unable to support even

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dimentary public health care system, let alone one directed toward providing comprehensive care. The financial incentives are often inadequate, and discriminatory reimbursement practices by third party payors for rural physicians compound the problem.²

SUPPORTING DATA

Geographic distribution

The geographic distribution of physicians by population in North Carolina is as follows: In rural North Carolina there are 1,737 people to each physician; there are 760 people to each physician in urban North Carolina. In rural North Carolina there are 2.3 times more people per physician than in urban areas of the state.³

In the six most populated counties in North Carolina, the population/physician ratio is 859:1. The population/physician ratio is 2,396:1 in the six least populated counties.⁴

Graduating physicians

Between 1958 and 1972 North Carolina had a total of 2,983 physician graduates.⁵ Bowman Gray School of Medicine had 776 (26 percent); Duke University Medical School had 1,226 (41 percent); and the University of North Carolina School of Medicine had 981 (33 percent).

Retention rates

Retention of North Carolina medical school graduates for practice in North Carolina allows three years for placement.⁶ Because of internship, residency, and military obligations, there is frequently a time lag of five to seven years between the time of graduation and establishment in practice. From 1955 to 1964, the number of physicians who graduated from North Carolina medical schools was 1,869; of these, 46 percent had settled in North Carolina as of 1967.

The retention rates for each of the schools are as follows: Bowman Gray School of Medicine—37 percent; Duke University Medical School—29 percent; University of

North Carolina School of Medicine—56 percent.

Primary care physicians in North Carolina

Of the 1,869 graduates from North Carolina Medical schools between 1955 and 1964, four hundred and two (22 percent) were practicing in North Carolina in the primary medical care specialties by the year 1972.⁷ The breakdown from the three schools is as follows: Bowman Gray School of Medicine—22 percent of 493 graduates; Duke University Medical School—13 percent of 782 graduates; University of North Carolina School of Medicine—32 percent of 594 graduates.

Of the 5,964 non-federal physicians practicing in North Carolina in 1971, 45 percent (2,583) were in the primary medical care specialties: 19 percent were in family medicine; 13 percent were in internal medicine; six percent were in pediatrics; and seven percent were in obstetrics-gynecology.⁸

Training programs for primary care specialties in North Carolina

In 1972 there were 703 residents in training in North Carolina, of whom 27 percent were in training in the primary care specialties.⁹

Relationships can be seen between the 45 percent of non-federal physicians practicing in North Carolina in the primary medical care specialties in 1971, the 27 percent of total residents in training in North Carolina in primary medical care specialties in 1972, and the recently adopted AMA goal that at least 50 percent of all medical graduates enter residency training in the primary care specialties in the coming years.

PREVIOUS STUDY REPORTS

The North Carolina Medical Society has long been interested in promoting realistic solutions to meet the problems of medical manpower, as evidenced by two reports in 1972 regarding "Medical Students and Medical Manpower" by the Joint Conference Committee, and the "Recommendations from the Conference on Access to Health Care"

by the Public Relations Committee. Recommendations regarding these problems, including the need for more medical school graduates in North Carolina, have been made in the "Report of the Statewide Plan for Medical Education in North Carolina" by a panel of medical consultants to the Board of Governors of the University of North Carolina. The UNC Board of Governors has prepared Recommendations Consistent with the Report of the Panel of Medical Consultants on a Statewide Plan for Medical Education in North Carolina. Separate recommendations have been prepared by the Medical Manpower Commission of the North Carolina State Legislature which call for the graduation of an increased number of physicians in North Carolina and the addition of a second year to the ECU Medical School.

RECOMMENDATIONS

Alleviating maldistribution

The scholarship or loan funds administered through the North Carolina Department of Human Resources to support medical education, with forgiveness of indebtedness if the student ultimately practices for a short length of time in rural areas, should be continued and enlarged.¹⁰

Medical school admission and recruitment criteria should be altered in favor of those factors in the applicant's background which might encourage him to practice in an underserved area. Medical students should be more oriented to the needs of medically deprived areas.¹¹

Admission committees to medical schools should include as full active members independent primary care physicians. Since this service can be very time consuming for a busy practitioner, reimbursement for time spent should be provided.¹²

In the selection criteria for scholarship recipients in the proposed scholarship program for undergraduate medical students, to be implemented by the Board of Governors of UNC for financially disadvantaged students, high priority should be given those applicants

who express an interest in entering a primary care specialty and serving in an underserved area.¹³

The Resident Physician-Preceptor Field Training Program for Primary Care - Family Practice Residents, being implemented by the North Carolina Department of Human Resources, should be supported and expanded. This program provides opportunities for primary care residents to receive part of their training in rural communities with selected medical practitioners.¹⁴

The statewide network for decentralization and coordination of medical and health professional education through development of Area Health Education Centers in North Carolina should be encouraged. The decentralization of undergraduate and graduate medical education through the greater use of community hospitals for intern and residency training will also be beneficial.¹⁵

Expansion of transportation and communication capabilities between rural areas and larger medical centers, presently in the planning stage by the Emergency Medical Services Network, should be accomplished, making adequate provision for appropriate reimbursement for medical services to be provided. Such reimbursement will be vital to the success of this program.¹⁵

The enhanced use of allied health professionals to increase the productivity of physicians, particularly those in rural areas, can be a beneficial influence. A program to help accomplish this, although not in itself a substitute for increased production of primary care physicians, is being implemented by the North Carolina Medical Society.¹⁶

The proposal to establish a network of primary medical care clinics throughout the state, as a cooperative endeavor between the community and the state, with supervision and backup by physicians and hospitals in nearby towns and cities, is an experimental program that deserves continuing support and guidance by the North Carolina Medical Society. The support of backup physician coverage will be vital to its success.¹⁷

Consideration should be given, with assistance from the interested agencies available, to expanding the function of the North Carolina Medical Society's Physician Placement Service to include development of demographic profile data on communities seeking a physician and active contact with physicians on behalf of such communities.¹⁸

New physicians moving into underserved areas should be allowed fee reimbursement for services provided, similar to those in other areas, and should not be limited for reimbursement to previously existing regional, prevailing fee schedules. These new reimbursement allowances should be included in determining prevailing fee schedules.¹⁹

Efforts such as job fairs, similar to the 1973 Student Physician Community Fair by the North Carolina Academy of Family Physicians, to bring physicians and rural leaders together should be supported and encouraged. Advance planning by representatives of parties involved and widespread publicity are important for the success of these programs.^{16, 20}

Correlating medical education with function

In the development of new curricula for medical students, further relevance should be sought by increased emphasis on performance criteria including task analysis and team concepts.¹¹ There should be greater interrelationship of training programs for medical and allied health professionals. Core courses in geographic proximity of the training programs to areas of need, as that envisioned in the expanded AHEC program, is one way to accomplish this.¹¹

The professional associations should provide programs to interest medical students in selecting primary care specialty, such as that provided by the North Carolina Family Practice Club of Medical Students.²⁰

Attractive credit-bearing electives in community primary medical care,

using practicing physician preceptors (not limited to the AHEC affiliated community hospitals mentioned in the preceding recommendation) should be developed so that as a goal, 25 percent of senior medical students' available elective time can be spent in rotations off university medical center campuses. Full reimbursement of student translocation expenses and appropriate preceptor reimbursement should be provided. Utilization of model medical practices, with physician preceptors who successfully demonstrate for medical students how underserved areas can effectively be served, should be given highest priority.^{16, 21}

To promote appropriate orientation as the programs of the medical schools move further into communities, it is recommended to the Chairman of the Board of Governors of UNC that a practicing physician, named by the North Carolina Medical Society, be added as an *officio* member of the proposed health subcommittee of the Committee on Educational Planning, Policies and Programs of that Board.

Increased funding should be provided for primary care physician training in North Carolina. This might include grants to departures for graduates after four years practice in North Carolina as primary care physicians.²²

The general requirements for residency programs, as enforced through the AMA Medical Specialties Review Teams, should be broadened and supervised to assure increased emphasis on the exposure of house officers to meaningful experiences in health and medical service outside the university medical center; orientation to the social and economic aspects of medical practice should be included.²³

It is important, in keeping with the recently adopted AMA goal, that at least 50 percent of all medical graduates enter residency training in the primary care specialties in the coming years.²⁴

Health care delivery systems

The Office of Comprehensive Health Planning in the North Car-

a Department of Administration is the responsibility of planning to meet the health needs of the people in North Carolina. Inadequate primary care services have been identified as a major health problem; yet, there are no primary care practicing physicians on the Comprehensive Health Planning Advisory Committee. There should be at least five practicing physicians on this Committee.²⁵

County medical societies, as far as possible, should consider taking on a population frame of reference" in which physicians accept not only an individual responsibility to individual patients but also cooperate by establishing responsibility to the geographic areas.²⁶ The regional approach for underserved areas, using satellite clinics which are staffed by health care teams composed of an allied health professional under physician supervision, is being implemented in North Carolina.¹⁷

Additional studies should be undertaken to determine newer methods of transportation to bring the needy to areas of existing health services.¹⁶

Efforts underway by the Emergency Medical Services Program to generalize the provision of emergency medical services in the community and to eliminate duplicate siting of emergency rooms in hospitals which are close together are important. Efforts should be continued to find more efficient and less costly ways to provide non-emergency, unscheduled care than by use of hospital emergency rooms.¹⁵

Community responsibility

There is an urgent need today for citizens in communities to examine their medical services' strengths and deficiencies. The people must establish the means for planning to assure optimum quality and continuity of comprehensive health services, moving through the designated regions of the Office of Comprehensive

Health Planning in cooperation with county medical associations. Every effort should be made on a regional and geographic basis to develop not only this entry point and access to primary care, but also the necessary secondary care in rural areas and backup tertiary care in strategically located medical centers. It is important for each community health planning committee with leadership from community physicians to establish long term goals to be accomplished in a stepwise fashion.²⁷ These goals should be as follows:

To make quality health care available for all people in the region: (1) Start with improvements in the area's transportation system to bring people to available physicians and hospitals in the region; (2) Secure cooperation of community colleges to train medical and dental assistants; (3) Contract with health departments to provide public health nurses; (4) Develop plans for providing new medical/dental clinics to help in recruitment of health personnel; (5) Seek to enlist the cooperation of medical and dental societies to provide added services; (6) Contract with local hospitals to establish emergency services; and (7) Establish improved ambulance services with better training and equipment for ambulance attendants.²⁷

To improve the family's ability to handle health problems: (1) Health education courses in schools for adults and children should be improved; (2) First aid courses for each family should be emphasized; (3) Self-help courses should be taught; and (4) Rural safety and accident prevention programs should be made available.²⁷

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Editorials

LOUISE FANT MacMILLAN

For almost a quarter of a century the day-to-day work of getting out the editorial matter of this JOURNAL has been done by Louise MacMillan. Authors and others in contact with the JOURNAL knew her as a very bright, well-read, experienced woman who epitomized Southern gentility. Few knew that she was paraplegic from birth, fewer still that until her 62nd year she rarely missed a day of work, justifying her own description of herself as "an able-bodied paraplegic." On March 2, 1973 she died, a victim of chronic active lupoid hepatitis, a disease she faced with her characteristic resolution and care for those who worried about her.

Miss MacMillan's life has special meaning for physicians, aside from her work with the JOURNAL, for medical situations currently hotly debated (N Engl J Med 289:890, 1973 and N Engl J Med 240:518, 1974) find illustration in her life.

Although born with spina bifida and paraplegia, she was born into a family with great intellectual and spiritual resources—the MacMillans who are so amply represented in North Carolina medicine, the Johnsons, Memories, Fants, and others of professional and literary acclaim in this state and elsewhere. Her father, a Baptist minister, many times literally carried Louise and saw to it that she mixed in the activities of the extended family, to the extent that she and they could manage. Thus she swam and played with her innumerable relatives of suitable age and grew to adulthood with great psychological strength. Many alumni of the Baptist orphanage in Thomasville remember with fondness Louise's work with the children and young people of that institution. At one time or another she was a teacher, editor, and counselor, succeeding her father as editor of *Charity and Children*, the statewide Baptist publication dealing with their orphanages. She found much time for service outside her work, being a deacon of the Wake Forest Baptist Church and president of the North Carolina Paraplegic Association, and active in both organizations until the last few months of her life. In 1963 she was designated "Handicapped Person of the Year," an honor fitly given. Although it could be said that we are all handicapped in some way, few people overcome a major handicap as well as Miss MacMillan did.

The JOURNAL, and especially Miss MacMillan's family, will miss her knowledge, judgment, and good

manners. The friends of her younger days think that her father will carry her into Heaven in his arms; they are both surely there.

DRUGS, REGULATION AND PROGRESS

In testimony before the Health Subcommittee of the Senate Committee on Health and Welfare December 19, 1973, HEW Secretary Casper Weinberger revealed a plan to limit reimbursement for drugs under Medicare and Medicaid to the least cost drugs available in the absence of demonstrated difference in therapeutic effect. Ostensibly, this proposal was designed to achieve economy in drug costs under these programs.

Testifying at a hearing before the same Committee on February 1, 1974, Joseph Stettin, formerly member of the AMA Staff and now president of the Pharmaceutical Manufacturers Association, properly urged a careful evaluation of this proposed regulation to determine whether it would: (1) achieve economies in these government programs; (2) interfere with the professional judgment of physicians and pharmacists; (3) assist or penalize beneficiaries; and (4) encourage, rather than retard, continued effort by pharmaceutical companies to improve drug quality and develop new products.

It is recognized that all drug products are not of equal quality. In 1967, then Secretary of HEW Garner estimated that the cost of establishing adequate facilities for scientific and clinical testing of all drugs by the Food and Drug Administration would approach \$75 million, while Secretary Weinberger projects a saving of only \$28 million to be achieved through his proposal. There is a question as to whether the FDA should replace the manufacturer's efforts in quality control or rather should complement such existing facilities.

The proposed regulation places in question the expertise of physicians and pharmacists. Freedom for the physician to exercise his judgment in the care of patients is at stake. Furthermore, any difference in cost not reimbursed under the Secretary's proposal would be borne by beneficiaries to their disadvantage.

A portion of the cost of drugs is necessarily a reflection of the outlay for quality testing and production of new drugs. Physicians and pharmacists are fully aware of significant progress incident to innovative and effective effort on the part of pharmacists.

manufacturers, particularly during the past three decades, in the control of pneumonia, tuberculosis, myelitis, and many other diseases. Regulatory measures must be carefully designed to avoid retardation of future progress.

J. S. R.

THE NORTH CAROLINA REGIONAL MEDICAL PROGRAM

As Executive Director of the North Carolina Regional Medical Program, I would like to thank our many physician friends for their loyalty and support during the past few years. I am not naive enough to believe that every physician in our state has fully agreed with the concepts and activities of the program. However, speaking in generalities, the support has been extremely gratifying. Without our close cooperative relationship with the North Carolina Medical Society we could not have survived.

As many of you are aware, this past year has been difficult and trying one for Regional Medical Programs throughout the nation. The threatened phase-out of the program in February 1973 markedly curtailed our activities for the first six months of that year. Owing to the efforts of many friends throughout the state and nation, both the Senate and House of Representatives, by overwhelming majorities, voted in June 1973 to extend the Regional Medical Programs (as well as 12 other health programs) for another year—to July 1, 1974. On June 18, 1973 President Nixon signed this bill, the Health Programs Extension Act, into law. The President likewise signed a continuing resolution authorizing these health agencies to spend the same amount of money as the previous year until the 1974 HEW Appropriation Bill was approved and signed by him.

It is true that, because of the uncertain future of the program, several key personnel of our program resigned last year and accepted positions elsewhere. Furthermore, the Office of Management and Budget in Washington impounded a large percentage of the funds that had been appropriated to Regional Medical Programs. In spite of these two facts, the North Carolina Regional Medical Program has continued to be a viable and active organization. Our operational projects are functioning satisfactorily, and a new application for our overall program for the fiscal year 1975 (July 1, 1974-June 30, 1975) is being prepared.

In the past several months two events have occurred that are most encouraging as far as the future of the program is concerned. First, in December 1973, President Nixon signed the fiscal year 1974 HEW Appropriation Bill, thus authorizing for Regional Medical Programs the funds requested by Congress. This meant that additional funds would be available for individual Regional Medical Programs for the remainder of this fiscal year. Sec-

ondly, in February 1974, Judge Flannery of the Federal Court of the District of Columbia, decreed that as a result of a suit brought by the National Association of Regional Medical Programs against the administration, the impounded funds due the Regional Medical Programs for the fiscal years 1973 and 1974 were to be released. This decision was a disappointment to the administration and a boost for the Regional Medical Programs. In simple terms, the impoundment of these funds was ruled illegal.

It is my opinion that the release of the impounded funds will make it possible for the North Carolina Regional Medical Program to continue in its present form for at least another year beginning July 1, 1974. Recently, several bills have been introduced in Congress advocating the coalition of several health agencies including the Regional Medical Programs, Comprehensive Health Planning and Hill-Burton. These bills differ in minor details. They will be the source of vigorous debate, and I doubt that any of them will be passed by Congress during the present session. We must prepare for the possibility that this coalition will occur in the future. It will not mean the demise of our program.

I think it is very important for the members of our State Medical Society to realize that their Past-President, President, President-Elect and six physicians appointed by the President are members of our governing group, known as the Regional Advisory Group. They thus play an important and essential role in all policy decisions that are made. Also, the North Carolina Regional Medical Program and the North Carolina State Medical Society are maintaining their close cooperation in continuing medical education.

Finally, at this time I wish to inform you that I have resigned my position as Executive Director of the North Carolina Regional Medical Program effective May 1, 1974. At that time Mr. Ben Weaver, who has been Deputy Director of the program since March 1970, will become Executive Director. We are indeed fortunate to have such a capable and experienced person to assume the leadership. I am extremely indebted and grateful to you for the encouragement and support that you have given me throughout these past four years.

F. M. SIMMONS PATTERSON, M.D.

RIGHT PHYSICIAN AT THE RIGHT TIME

The most pressing health issue in North Carolina is the concern of the citizens of our state regarding the need for more primary care physicians, as well as for a more effective distribution of primary care physicians.

The article, "Need for More and Better Distributed Primary Care Physicians in North Carolina," which appears in this issue of the JOURNAL, is a proposed

position paper by the Committee on Community Medical Care. It reviews the related problems of inadequate primary medical care and maldistribution from the practitioners' vantage point, and it provides relevant data from which recommendations have been made.

Most people hold their personal physician in high esteem because they know him to be well informed, compassionate, and responsive to their needs. In keeping with tradition, it is important for organized medicine to respond similarly to statewide health problems.

Position papers on important issues of the day, prepared by interested and informed committees of the North Carolina Medical Society and approved by the House of Delegates, are already available on a number of topics; included are "Medical Aspects of Sports," "Medico-Legal Code of North Carolina," and "Statement of Principles on Mental Health."

In order that we continue to provide the best medical care system for the people of our state, it is important in the management of health problems that we propose our own solutions rather than have political solutions imposed upon us.

The proposed position paper on "Need for More and Better Distributed Primary Care Physicians in North Carolina" is commended to your attention.

JOHN L. MCCAIN, M.D.

Emergency Medical Services



A "NEW ROLE" FOR THE EMERGENCY DEPARTMENT NURSE

Ruth M. Miller, R.N., President
Emergency Department Nurses Association
Community Hospital of South Broward
Hollywood, Florida

In her article, Ms. Miller has identified a major need for special educational programs to prepare emergency department nurses to function in their "new role." The expanded role to which she refers includes performing complex technical procedures, teaching paraprofessional emergency personnel, and coordinating many aspects of patient care in addition to the "traditional" role of the nurse. This new role requires special skills and knowledge in "observation" and assessment, resuscitation, and stabilization of the acutely ill and injured.

EDNA, the nationwide Emergency Department Nurses Association, of which Ms. Miller is president,

Rondomycin (methacycline HCl)

CONTRAINDICATIONS: Hypersensitivity to any of the tetracyclines

WARNINGS: Tetracycline usage during tooth development (last half of pregnancy to early months) may cause permanent tooth discoloration (yellow-gray-brown), which is more common during long-term use but has occurred after repeated short-term courses. Enamel hypoplasia has also been reported. Tetracyclines should not be used in this group unless other drugs are not likely to be effective or are contraindicated.

Usage in pregnancy. (See above **WARNINGS** about use during tooth development.) Animal studies indicate that tetracyclines cross the placenta and can be toxic to the developing fetus (often related to retardation of skeletal development). Embryotoxicity has also been noted in animals treated early in pregnancy.

Usage in newborns, infants, and children. (See above **WARNINGS** about use during tooth development.)

All tetracyclines form a stable calcium complex in any bone-forming tissue. A decrease in fetal bone growth rate observed in premature given oral tetracycline 25 mg/kg every 6 hours was reversible when drug was discontinued.

Tetracyclines are present in milk of lactating women taking tetracyclines.

To avoid excess systemic accumulation and liver toxicity in patients with impaired renal function, reduce usual total dosage and, if therapy is prolonged, consider serum level determinations of drug. The anti-anabolic action of tetracyclines may increase BUN. It is not a problem in normal renal function. In patients with significantly impaired function, higher tetracycline serum levels may lead to azotemia, hyperphosphatemia, and acidosis.

Photosensitivity manifested by exaggerated sunburn reaction has occurred with tetracyclines. Patients apt to be exposed to direct sunlight or ultraviolet light should be so advised, and treatment should be discontinued at first evidence of skin erythema.

PRECAUTIONS: If superinfection occurs due to overgrowth of nonsusceptible organisms including fungi, discontinue antibiotic and start appropriate therapy.

In venereal disease, when coexistent syphilis is suspected, perform darkfield examination before therapy, and serologically test for syphilis monthly for at least four months.

Tetracyclines have been shown to depress plasma prothrombin activity; patients on anticoagulant therapy may require downward adjustment of their anticoagulant dosage.

In long-term therapy, perform periodic organ system evaluations (including blood, renal, hepatic).

Treat all Group A beta-hemolytic streptococcal infections for at least 10 days. Since bacteriostatic drugs may interfere with the bactericidal action of penicillin, always give tetracycline with penicillin.

ADVERSE REACTIONS: Gastrointestinal (oral and parenteral forms): anorexia, nausea, vomiting, diarrhea, glossitis, dysphagia, enterocolitis, inflammatory lesions (with local overgrowth) in the anogenital region.

Skin: maculopapular and erythematous rashes, exfoliative dermatitis (uncommon). Photosensitivity is discussed above. (See **WARNINGS**.)

Renal toxicity: rise in BUN, apparently dose related. (See **WARNINGS**.)

Hypersensitivity: urticaria, angioneurotic edema, anaphylaxis, anaphylactoid purpura, pericarditis, exacerbation of systemic lupus erythematosus.

Bulging fontanels, reported in young infants after full therapeutic dosage, have disappeared rapidly when drug was discontinued.

Blood: hemolytic anemia, thrombocytopenia, neutropenia, eosinophilia.

Over prolonged periods, tetracyclines have been reported to produce brown-black crossopigment discoloration of thyroid glands; no abnormalities of thyroid function studies known to occur.

USUAL DOSAGE: Adults—600 mg daily, divided into two or four equally spaced doses. More severe infections: an initial dose of 300 mg followed by 150 mg every six hours. 300 mg every 12 hours. Gonorrhea: In uncomplicated gonorrhea, when penicillin is contraindicated, Rondomycin (methacycline HCl) may be used for treating both males and females in the following clinical dosage schedule: 900 mg initially, followed by 300 mg i.d. for a total of 5.4 grams.

For treatment of syphilis, when penicillin is contraindicated, a total of 18 to 24 grams Rondomycin (methacycline HCl) in equally divided doses over a period of 10-15 days should be given. Close follow-up, including laboratory tests, is recommended.

Eaton Agent pneumonia: 900 mg daily for six days.

Children—3 to 6 mg/lb. day divided into two to four equally spaced doses. Therapy should be continued for at least 24-48 hours after symptoms and fever have subsided.

Concomitant therapy: Antacids containing aluminum, calcium or magnesium impair absorption and are contraindicated. Food and some dairy products also interfere. Give one hour before or two hours after meals. Pediatric oral dosage forms should not be given with milk formulas and should be given at least one hour prior to feeding.

In patients with renal impairment (see **WARNINGS**), total dosage should be decreased by reducing recommended individual doses or by extending time intervals between doses.

In streptococcal infections, a therapeutic dose should be given for at least 10 days.

SUPPLIED: Rondomycin (methacycline HCl) 150 mg and 300 mg capsules, syrup containing 75 mg/5 cc methacycline HCl.

Before prescribing, consult package circular or latest PDR information.



WALLACE PHARMACEUTICALS
CRANBURY, NEW JERSEY 08512

promoting the development of educational programs and national standards for emergency department nurses. This effort is consistent with EDNA's stated belief that "it is the responsibility of hospital administrations and nurses alike to assure that only adequately trained and oriented personnel work in emergency departments. Ms. Miller asserts that educational programs to provide initial training for these personnel and structured continuing education programs are essential to attaining this goal. She maintains that increased public awareness of emergency

medical services has placed the emergency department nurse in a very visible position from which the nurse has a new opportunity as well as a "new role."

Abstracted by MARY C. DAVISON, R.N.

From "Emergency Medicine Today," AMA Commission on Emergency Medical Services, Volume 3, No. 1, John M. Howard, Editor. Original article can be obtained from the American Medical Association, 535 North Dearborn Street, Chicago, Illinois 60610.

Committees and Organizations

AD HOC COMMITTEE TO STUDY AND RECOMMEND A SALARY OR INCREASE IN ALLOWANCES FOR THE PRESIDENT

Southern Pines, Sept. 29, 1973

This Committee was appointed by President John Cession at the direction of the House of Delegates at the annual meeting in May 1973. After a lengthy discussion, the Committee submitted the following statement to the Executive Council:

We recommend that the Society continue to pay reimbursable expenses attendant to the President including necessary travel, housing, food, communi-

cations, and out-of-pocket secretarial expenses; and that, in addition, the Society pay a per diem at the rate of \$25 per day for days, or parts of days, spent by the President outside of the home town on Society business.

We further recommend, in alleviating the burden of assuming the Presidency, that the President-elect and the immediate past-President be reimbursed for their travel and living expenses when, by virtue of their office, they are involved in official Medical Society functions.—GEORGE W. PASCHAL, JR., M.D., Chairman

Bulletin Board

NEW MEMBERS of the State Society

Adad, Wahaj Din, MD (N), 521 Beaumont Dr., Fayetteville 28304
Amin, Henry Vann, MD (IM), Box 551, Pinehurst Med. Ctr., Pinehurst 28374
Acock, Perry Wm., Jr., MD (IM), 1896 Remount Rd., Gastonia 28052
Bail, Haynes Wallace, MD (PTH), 1200 N. Elm St., Greensboro 27401
Bates, Robert Paul, MD (Intern-Resident), Box 3371, Duke Med. Ctr., Durham 27710
Barn, Joseph James, MD (FP), 146 E. McLelland Ave., Mooresville 28115

Bethea, Wm. Thaddeus, Jr., MD (OM), Rt. 4, Turnpike Rd., Box 223-W, Laurinburg 28352
Boehmke, Fred Edward, MD (Intern-Resident), 4315 Morningside Dr., Winston-Salem 27106
Browning, Frank Ward, MD (OPH), 1629 Owen Dr., Fayetteville 28304
Chung, Joseph Y., MD (GS), Fleming Avenue, Marion 27858
Clark, Perry Belton, MD (OBG), 3890 Sturbridge, Winston-Salem 27103
Cole, Buell Carlton, MD (SG), Wake Forest Surgical Center, S. Allen Road, Wake Forest 27587
Crane, Larry Martin, MD (Intern-Resident), 2312 Oriole Dr., Durham 27705
Crook, John Newman, MD (GS), 486 Crestside, SE, Concord 28025
Elliston, Erwin Bruce, MD (Intern-Resident), 1426 Colewood Dr., Durham 27705
Francis, Edwin Howard, MD, Moore Memorial Hospital, Pinehurst 28374

Fulk, Robert Vernon, Jr., MD (OTO), Suite 10-A Murchison Bldg., Wilmington 28401
 Garside, Wm. Blake, MD (PL), 3924 Browning Place, Raleigh 27609
 Gibson, Robert Wylie, MD (P), 15 Staff Circle, Morganton 28655
 Glass, Frederick Wm., MD (GS), Bowman Gray School of Med., Winston-Salem 27103
 Gomez, Raul Fernando, MD (IM), Bordeaux Center, Owen Dr., Fayetteville 28304
 Hermann, Arlene Martone, MD (GP), 110 Doctors Bldg., Franklin 28734
 Hermann, James Howard, MD (GP), 110 Doctors Bldg., Franklin 28734
 Jones, Thaddeus Leroy, MD (PTH), 5835 Beckett Court, Charlotte 28211
 Lane, Robert Earl, MD (GP), 304 S. Granville St., Edenton 27932
 Lopez, Clemenceau DeJesus, MD (GP), Gooden St., Elizabethtown 28337
 McNeil, Jesse Neal, MD (P), 2281 Lakeview Terrace, Burlington 27215
 Metzgerott, Kirk Oliver, MD (AN), P. O. Box 2554, Charlotte Mem. Hospital, Charlotte 28201
 Mullins, Patrick S., MD, 111 Fairway Road, Morehead City 28557
 Murray, Gordon F., MD (GS), UNC Cardiovascular Surgery, Chapel Hill 27514
 Nebel, Edward Joseph, MD (ORS), 5108 Pine Tree Lane, New Bern 28560
 Nixon, Wm. Preston, Jr., MD (Intern-Resident), 3249 Duke Homestead Rd., Durham 27701
 Ostdahl, Roger Harold, MD (Intern-Resident), Box 3955, Duke Medical Ctr., Durham 27710
 Pena, Horacio, MD (GP), P. O. Box 308, Clarkton, N. C.
 Phillips, Bruce Alton, Jr., MD (IM), P. O. Box 86, Elizabethtown 28337

Pratt, Laura Winstead, MD (FP), P. O. Box 725, Bangor Elk 28604
 Palmgren, Einar Alexander, MD (OTO), 224 S. New Hope Rd., Gastonia 28052
 Procter, James Thornton, MD (P), 1200 Glade St., Winston-Salem 27101
 Riddick, Joseph Henry, Jr., MD (PTH), 200 Hawthorne Ln., Charlotte 28204
 Sandridge, David Allen, MD (OBG), 5 Doctors Pl., Asheville 28801
 Santos, Jose Eugenio, MD (Intern-Resident), Box 7504, Raleigh 27611
 Schiwm, Arlen Lee, MD (D), 6608 Lynmont Dr., Charlotte 28211
 Slawek, David F., MD (IM), 501 6th Ave., West, Hendersonville 28739
 Stein, Michael Albert, MD (GS), 1300 Lexington Ave., Thomasville 27360
 Stephenson, Thomas Noel, MD (Intern-Resident), Box 312, Duke Med Ctr., Durham 27710
 Stringer, Llewellyn Winn, MD (AN), 3131 Kinnamon Ln., Winston-Salem 27103
 Taylor, Richard Allen, MD (PD), 1524 Harding Pl., Charlotte 28204
 Vaughan, Thomas June, MD (R), 632 Hertford Ln., Winston-Salem
 Weaver, Phillip David, MD (R), 304 Charlotte St., Rocky Mount 27801
 Webster, Joel Stoops, MD (CDS), 2001 Vail Ave., Charlotte 28207
 West, George Harper, MD (IM), 1005 N. College St., Kinston 28501
 White, Jess Alexander, Jr., MD (OBG), Rt. 3, Box 1, Hickory 28601

ANESTHESIOLOGY PLACEMENT SERVICE

For Locations in North Carolina desiring the services of an anesthesiologist and for anesthesiologists wishing to locate or relocate in North Carolina

CONTACT:

Placement Service
 N. C. Society of Anesthesiologists
 Department of Anesthesiology
 North Carolina Memorial Hospital
 Chapel Hill, North Carolina 27514

WHAT? WHEN? WHERE?

In Continuing Education

April 1974

("Place" and "sponsor" are listed only where these differ from the place and group or institution listed under "information.")

In North Carolina

April 18-21

Introductory and Advanced Courses in Clinical Hypnosis
 Place: Ramada Inn, 3920 Arrow Drive, Raleigh, by Gateway Shopping Center

Program designed to present practical principles for the beginning utilization of hypnosis in treatment for the physician, dentist and clinical psychologist, with special clinical hypnotherapy seminars for advanced students.

Fee: ASCH members \$50; non-members \$125; special consideration given to students of medicine, dentistry and psychology.

Credit: 21 hours AMA Category 1 accreditation; AAFP credit applied for.

For Information: Mr. F. D. Nowlin, Executive Secretary, The American Society of Clinical Hypnosis, 800 Washington Ave. S.E., Minneapolis, Minnesota 55414.

April 20

Present Concepts on Knee Problems

Place: Royal Villa Hotel, Raleigh

Sponsor: American Academy of Orthopaedic Surgeons (roduced by The Committee on Adult Musculoskeletal Diseases)

Fee: \$40; residents \$20. Registration limited to 100.

Credit: Approved for five prescribed hours by AAFP

For Information: Thomas B. Dameron, Jr., M.D., F.O., Box 10707, Raleigh 27605

April 24-25

Third Annual Cancer Symposium
Place: Downtown Holiday Inn, Raleigh
Sponsors: North Carolina Central Cancer Registry; North Carolina Regional Medical Program; American Cancer Society, North Carolina Division
For Information: Cory Menees, Cancer Program Manager, P. O. Box 2091, Raleigh 27602

April 26-28

Annual Meeting of the American Association of Medical Assistants, North Carolina State Society
Place: Hilton Inn, Winston-Salem
Program: Keynote speaker, George G. Gilbert, M.D., President, North Carolina Medical Society. Mr. Mike Silver of Conomikes Associates will present a program on managing the patient, the office, and the physician. Physicians and their assistants are urged to attend.
Fee: \$30
For Information: Mrs. June Aysse, 911 Hay Street, P. O. Box 3514, Fayetteville 28305

April 27

Waven-Pamlico Annual Medical Society Symposium
Place: Ramada Inn, New Bern
For Information: Zack J. Waters, M.D., 800 Hospital Drive, New Bern 28560

May 1

Diabetic Complications: Are They Preventable?, a one day symposium.
Place: The Governor's Inn, Research Triangle Park
Sponsors: North Carolina Diabetes Association and the Department of Medicine, Duke University Medical Center
Fee: \$15
For Information: Jerome M. Feldman, M.D., Box 2963, Duke University Medical Center, Durham 27710

May 1 and May 2

PAS and MAP Medical Audit Seminars
Places: May 1—Moose Lodge, Greenville; May 2—Holiday Inn West, Winston-Salem
Sponsors: The Commission on Professional and Hospital Activities in cooperation with North Carolina Medical Society, North Carolina Hospital Association, North Carolina Chapter of the Hospital Financial Management Association, North Carolina Blue Cross and Blue Shield, and The Duke Endowment Program: The program will emphasize in formal presentation and laboratory session the effective and efficient use of the PAS system to do medical audit studies and utilization review.
Fee: \$35; seminars open to physicians, hospital trustees and administrators, health record analysts, medical record administrators, and health organization representatives.
For Information: CPHA, 1968 Green Road, Ann Arbor, Michigan 48105

May 4-5

Principles of Practical Oxygen Therapy, which had been scheduled for this date, has been postponed until later.
For Information: Miss Ann Francis, Administrative Assistant, Office of Continuing Education, School of Medicine, UNC, Chapel Hill 27514

May 6-8

Applications of PSRO for Hospital Management
Place: Key Bridge Marriott, Arlington, Virginia
Fee: ACHA affiliates \$225; non-affiliates \$275
For Information: American College of Hospital Administrators, 840 North Lake Shore Drive, Chicago, Illinois 60611

May 6-24

Care of the Patient—Valvular Heart Disease and Cardio-myopathies
Fee: \$200
For Information: Laurice Ferris, R.N., Continuing Education, UNC School of Nursing, Chapel Hill 27514

May 8-9

Path of Spring '74—Respiratory Care Symposium
Place: Babcock Auditorium
For Information: Emery C. Miller, M.D., Associate Dean

for Continuing Education, Bowman Gray School of Medicine, Winston-Salem 27103

May 9-10

Hospital-Health Insurance Institute
Place: Wilmington Hilton, Wilmington
Program designed for personnel responsible for handling hospital and medical claims in the hospital, physician's office and insurance company health claims office.
Fee: \$20
For Information: Mr. Al Rinne, North Carolina Hospital Association, P. O. Box 10937, Raleigh 27605

May 14-16

The Neuro-endocrinology Symposium: Neurobiology of CNS—Hormone Interaction
Place: UNC Student Union Building, Great Hall
Sponsors: UNC Neurobiology Program and Laboratories for Reproductive Biology
For Information: Miss Ann Francis, Administrative Assistant, Office of Continuing Education, UNC School of Medicine, Chapel Hill 27514

May 15

Ethel Nash Day Program
Place: Clinic Auditorium. Time: 1:00-5:30 p.m.
Sponsor: Department of Obstetrics and Gynecology
For Information: Miss Ann Francis, Administrative Assistant, Office of Continuing Education, UNC School of Medicine, Chapel Hill 27514

May 16-18

Basic Mechanisms in Hypertension
Place: Babcock Auditorium
Sponsor: American Heart Association Basic Science Council
For Information: Emery C. Miller, M.D., Associate Dean for Continuing Education, Bowman Gray School of Medicine, Winston-Salem 27103

May 18-22

120th Annual Session of the North Carolina Medical Society; General Session on Scientific Subjects and Specialty Section Meetings
Place: Pinehurst Hotel and Country Club
For Information: Mr. William N. Hilliard, Executive Director, P. O. Box 27167, Raleigh 27611

May 20-21 and May 23-24

Nursing Evaluation and Documentation
Place: Royal Villa, Raleigh, May 20-21; Downtowner East, Charlotte, May 23-24
Intended Participants: Hospital nursing personnel
Fee: \$75
For Information: Mr. Jay Camp, North Carolina Hospital Association, P. O. Box 10937, Raleigh 27605

May 28-31

Fourth postgraduate course in Head & Neck Anatomy
Sponsors: Department of Anatomy, School of Medicine, in cooperation with the Division of Continuing Education, East Carolina University
Eligibility: Open to holders of any of following degrees: M.D., D.D.S., D.M.D., Ph.D.
Fee: \$125; students in residency programs \$75
Credit: Approved for 28 hrs. AAFP elective hours; CE units also given by Division of Continuing Education, ECU
For Information: Head & Neck Anatomy Course, ECU Division of Continuing Education, P. O. Box 2727, Greenville 27834

May 29-30

Hypertension: Critical Problems—25th Annual Meeting and Scientific Sessions, North Carolina Heart Association
Place: Hyatt House and Convention Center, Winston-Salem
Designed especially for nurses and physicians
For Information: North Carolina Heart Association, 1 Heart Circle, Chapel Hill 27514

June 12-15

Neurology for Practicing Physicians, originally scheduled

by the Bowman Gray School of Medicine for this date, has been cancelled.

June 20-22

Mountain Top Assembly
Place: Waynesville Country Club, Waynesville
For Information: R. Stuart Roberson, M.D., P. O. Box 307, Hazlewood 28738

July 8-13

16th Annual Duke Medical Post Graduate Course
Place: Atlantis Lodge, Atlantic Beach, North Carolina
Program: designed primarily for the generalist, but with sufficient variation to appeal to the interest of the internist and the pediatrician. Conferences and lectures will be given in the morning; afternoons and evenings will be left free for recreational activities.
Fee: \$85, payable in advance. Course limited to 75 participants.
Credit: A certificate of attendance will be given. Program is acceptable for 30 accredited hours by AAFP.
For Information: W. M. Nicholson, M.D., P. O. Box 3088, Duke University Medical Center, Durham 27710.

July 29-August 2

2nd Annual Beach Workshop: Selected Topics in General Internal Medicine
Sponsors: Bowman Gray, Duke and UNC Schools of Medicine, in conjunction with the Medical University of South Carolina
Place: St. Johns Inn, Myrtle Beach, South Carolina
Fee: \$100
For Information: Emery C. Miller, M.D., Associate Dean for Continuing Education, Bowman Gray School of Medicine, Winston-Salem 27103

September 20-21

1974 Walter L. Thomas Symposium on Gynecologic Malignancy and Surgery
Program: The two day symposium will be clinically oriented with the main emphasis on "Ovarian Cancer" and "Difficult Office Gynecology." Invited guest speakers include Dr. J. Donald Woodruff, Baltimore, Maryland; Dr. Herbert Buchsbaum, Iowa City, Iowa; and Dr. J. Taylor Wharton, Houston, Texas.
Credit: AAFP credit applied for.
For Information: W. T. Creasman, M.D., Director of Gynecologic Oncology, P. O. Box 2079, Duke University Medical Center, Durham 27710

* * *

Loan Materials Available

A packet of materials to help you Train Your Own Assistant is available to members on a loan basis from Medical Society headquarters. It includes a color TV tape cassette, practice forms for planning and evaluation, and TV tape evaluation report forms. For more information write Mr. Gene Sauls, North Carolina Medical Society, P. O. Box 27167, Raleigh 27611.

* * *

In Contiguous States

April 16

Fourth Annual Charles W. Thomas Lecture
Place: George Ben Johnston Auditorium
Sponsor: Division of Connective Tissue Diseases
For Information: Department of Continuing Education, Medical College of Virginia, Box 91, MCV Station, Richmond, Virginia 23298

April 20-24

"Selection of Materials for Reconstructive Surgery," the Sixth International Biomaterials Symposium
Designed to bring together clinicians in orthopedics, oral surgery, plastic and reconstructive surgery with leading researchers in biomaterials, biomechanics, biophysics and experimental surgery
Place: Clemson University, Clemson, South Carolina
For Information: Dr. Samuel F. Hulbert, Dean of Engineering, Tulane University, New Orleans, Louisiana 70118

PRESCRIBING INFORMATION Antiminth (pyrantel pamoate) Oral Suspension

Actions. Antiminth (pyrantel pamoate) has demonstrated anthelmintic activity against *Enterobius vermicularis* (pinworm) and *Ascaris lumbricoides* (roundworm). The anthelmintic action is probably due to the neuromuscular blocking property of the drug.

Antiminth is partially absorbed after an oral dose. Plasma levels of unchanged drug are low. Peak levels (0.05-0.13 µg/ml.) are reached in 3 hours. Quantities greater than 5% of administered drug are excreted in feces as the unchanged form, whereas only 7% or less of the dose is found in urine as the unchanged form of the drug and its metabolites.

Indications. For the treatment of ascariasis (roundworm infection) and enterobiasis (pinworm infection).

Warnings. *Usage in Pregnancy:* reproduction studies have been performed in animals and there was no evidence of propensity for harm to the fetus. The relevance to the human is not known.

There is no experience in pregnant women who have received this drug.

Precautions. Minor transient elevations of SGOT have occurred in a small percentage of patients. Therefore, this drug should be used with caution in patients with pre-existing liver dysfunction.

Adverse Reactions. The most frequently encountered adverse reactions are related to the gastrointestinal system.

Gastrointestinal and hepatic reactions: anorexia, nausea, vomiting, gastralgia, abdominal cramps, diarrhea and tenesmus, transient elevation of SGOT.

CNS reactions: headache, dizziness, drowsiness, and insomnia. Skin reactions: rashes.

Dosage and Administration. *Children and Adults:* Antiminth Oral Suspension (50 mg. of pyrantel base/ml.) should be administered in a single dose of 11 mg. of pyrantel base per kg. of body weight (or 5 mg./lb.); maximum total dose 1 gram. This corresponds to a simplified dosage regimen of 1 cc. of Antiminth per 10 lb. of body weight. (One teaspoonful = 5 cc.)

Antiminth (pyrantel pamoate) Oral Suspension may be administered without regard to ingestion of food or time of day; and purgation is not necessary prior to, during or after therapy. It may be taken with milk or fruit juices. Because of limited data on repeated doses, no recommendations can be made.

How Supplied. Antiminth is available as a pleasant tasting caramel-flavored suspension which contains the equivalent of 50 mg. pyrantel base per ml., supplied in 60 cc. bottles.

ROERIG Pfizer
A division of Pfizer Pharmaceuticals
New York, New York 10017

WORMS BLITZED



A single dose of Antiminth (1 cc. per 10 lbs. of body weight, 1 tsp./50 lbs. — maximum dose, 4 tsp.=20 cc.) offers highly effective control of *both* pinworms and roundworms.

Antiminth has been shown to be extremely well tolerated by children and adults alike in clinical studies*. Pleasantly caramel-flavored, it is non-staining to teeth and oral mucosa on ingestion... doesn't stain stools, linen or clothing.

One prescription can economically treat the entire family.

ROERIG *Pfizer*

A division of Pfizer Pharmaceuticals
New York, New York 10017

**Pinworms, roundworms controlled
with a single, non-staining dose of
ANTIMINTH[®]
(pyrantel pamoate)**

equivalent to 50 mg. pyrantel/ml.
ORAL SUSPENSION

Please see prescribing information on facing page.

May 6-9

The Recognition and Management of Coronary Syndromes
Place: Royal Coach Motor Hotel, Atlanta, Georgia
Sponsors: American Heart Association Council on Clinical
Cardiology and the Department of Medicine of Emory
University School of Medicine

For Information: Miss Mary Anne McInerney, Director,
Department of Continuing Education Programs, American
College of Cardiology, 9650 Rockville Pike, Bethesda,
Maryland 20014

Items submitted for listing should be sent to: WHAT?
WHEN? WHERE?, P. O. Box 8248, Durham NC 27704,
by the 10th of the month prior to the month in which
they are to appear.

News Notes from the—

UNIVERSITY OF NORTH CAROLINA DIVISION OF HEALTH AFFAIRS

Dr. William E. Easterling, Jr., is the new chief of staff at the North Carolina Memorial Hospital and an assistant dean of the UNC School of Medicine. He succeeds Dr. William J. Cromartie, who has served as chief of staff since 1969. Dr. Cromartie will continue as associate dean for clinical sciences in the School of Medicine.

* * *

Dr. Carl M. Shy has been named director of the UNC Institute for Environmental Studies. He is former director of the Human Studies Laboratory of the Environmental Protection Agency (EPA) in Research Triangle Park. Dr. Shy holds the medical degree from Marquette University and the master's and doctor's degrees in public health from the University of Michigan.

Responsible to Dr. Cecil G. Sheps, UNC vice chancellor for health sciences, the Institute will coordinate and fund research which will focus on environmental needs of North Carolina.

* * *

The UNC School of Medicine is one of eight medical schools in the United States and Canada selected for the Robert Wood Johnson Clinical Scholars' Program. The program is designed to develop doctors skilled in finding better ways to deliver health services, especially in the area of primary care.

UNC will be funded from 1974 to 1977. The \$727,000 grant will provide for two-year support and training of 18 scholars. Six scholars will be named each year.

The Johnson Foundation hopes the program will find out how doctors can be more effective in treating patients. It also wants to know what doctors can do to measure the costs and benefits derived from different kinds of health care systems.

William F. Vann, Jr., chairman of the Council of Students of the American Association of Dental Schools, is the winner of the 1974 Morehead Fellowship in Dentistry at UNC.

A graduate of Auburn University, Vann is a four-year student in the School of Dentistry at the University of Alabama. He is president of the dental student government association. Last year he was member of the editorial board of "Dental Student News," the publication of the American Association of Dental Schools.

At UNC he will pursue postdoctoral studies in pedodontics, the treatment of children. The Morehead Dental Fellowship is valued at \$5,000 plus tuition and fees to cover expenses during two years of study in the UNC School of Dentistry.

* * *

Dr. Paul A. Obrist, Department of Psychiatry, was elected President-elect of the Society for Psychophysiological Research (SPR) at their thirteenth annual meeting held in Galveston, Texas on October 25-28, 1973.

The SPR is an international, interdisciplinary group of researchers with a current membership of 700; their bi-monthly journal is *Psychophysiology*. The general thrust of the research is aimed at the interrelationships between behavioral and biological events both at a basic and clinical level. Illustrative of the clinical application of the research are the current efforts using biofeedback techniques to modify visceral events such as electrical abnormalities of the heart and blood pressure.

* * *

Dr. Colin G. Thomas, chairman of the Department of Surgery, UNC School of Medicine, spoke at "Small Intestinal Atresia—The Critical Role of Functioning Anastomosis" on Dec. 3-5 to the Southern Surgical Association in Hot Springs, Virginia.

Also attending the meeting from the Department of Surgery were Drs. Stanley R. Mandel, James L. Newsome and George Johnson, Jr.

* * *

The Psychoanalytic Clinic of the UNC Department of Psychiatry has been established for the evaluation of persons potentially interested in psychoanalytic treatment, to be a source of information about such treatment, and to assist in arrangements for it.

It is staffed by students and faculty of the UNC-Duke Psychoanalytic Training Program, with M. J. Miller, M.D. as director. The Clinic operations will be under the direction of Roger F. Spencer, M.D. Fees will be assessed according to individual means, and no one will be excluded on financial grounds. Location of the central appointments secretary is: Room 237, Old Nurses Dorm, UNC Department of Psychiatry, telephone number: 966-4224.

DUKE UNIVERSITY MEDICAL CENTER

Two distinguished economists at Duke have been awarded a National Science Foundation grant to study the effects of the trend toward zero population growth on the nation's economy.

The two are Dr. Joseph J. Spengler, James B. Duke professor emeritus of economics, and Dr. Juanita M. Kreps, also a James B. Duke professor of economics. One of Spengler's primary interests over the past 40 years has been problems of population and resources, and Kreps is a widely known specialist in the economics of aging.

The \$67,000 grant is from Research Applied to National Needs (RANN), a section of the National Science Foundation. The two economists will be working as research investigators in the Center for the Study of Aging and Human Development.

Dr. George Maddox, director of the center, said demographers have forecast that the nation is moving toward a stable population in which the number of births will equal the number of deaths. Throughout the history of the United States, the birth rate has far outstripped the death rate.

As the birth rate decreases, the proportion of elderly people in our population grows, Maddox said. No one yet knows what percentage of the population will be in the elderly age bracket when we reach zero population growth, he said.

This will be one of the questions Spengler and Kreps will address. Another area deals with the economic implications of the emerging age structure of the population.

* * *

The National Institute of Allergy and Infectious Diseases (NIAID) is creating an Asthma and Allergic Disease Center here.

The Duke project, one of a national network of 17 centers, will be headed by Dr. Rebecca H. Buckley, associate professor of both pediatrics and immunology.

NIAID will provide \$127,206 to support the center's research for three years. Scientists in the project will study the basic mechanisms involved in allergy.

The study will focus on mechanisms leading to increased production of immunoglobulin E (IgE) antibodies.

The researchers will study facets of immunity in allergic people as well as in other persons with high IgE levels who are also very susceptible to infections in an effort to find out what leads to the increased synthesis of IgE. The goal is to find a means of treatment which will "turn off" the increased production.

NIAID is an arm of the Department of Health, Education and Welfare.

Energy conserving efforts begun here in the fall have resulted in a substantial savings in both money and the amount of electricity used.

The reduction of lighting in non-essential areas is expected to save the medical center \$14,979 yearly. In addition, the shutting off of certain large air handling units where there are no employees after 6 p.m. should save another \$14,040 over the next 12 months.

* * *

Harbor Branch Foundation of Florida has awarded the medical center a \$300,000 grant for a program of simulated dives in the hyperbaric chamber aimed at working out a new set of decompression timetables for divers.

Dr. Peter B. Bennett, professor of anesthesiology and biomedical engineering, is the principal investigator on the project.

The program will run 12 to 18 months with a total of 100 to 120 dives. It will evaluate decompression times of 30, 45, and 60 minutes from depths of 450 to 650 feet.

Experienced divers from Oceaneering International, Inc. of Houston, a commercial diving firm, will take part in the project. Harbor Branch and Oceaneering will also provide technical support for the project.

Bennett said the study is being undertaken because decompression tables now in use do not always prevent decompression sickness or "bends," especially at the deeper depths.

The exploration for offshore oil requires divers to operate from oil rigs. As the depth of their operation has increased, so have the decompression dangers to the divers.

The decompression tables and knowledge obtained from this study will be generally available to all diving organizations, and Bennett said it is hoped that this will greatly improve the safety and health of working divers.

* * *

The model family practice clinic operated by the medical center and Watts Hospital will move into expanded offices soon to provide training for more family doctors and offer medical care to larger numbers of Durham residents.

Dr. William J. Kane, who became director of the Duke/Watts Family Practice Residency Training Program Jan. 1, said the new office at 719 Broad St. will have 14 to 16 examining rooms. The present clinic at 1010 Broad St. has only four examining rooms.

The name of the model clinic has been changed from Durham Health Care to the Family Medicine Center.

Kane said there are now 10 residents in the three-year training program, and eight first year residents will be added in July. In July of 1975 another first-year class of eight will be added, he said, and from

then the program will be stabilized at a level of 24 trainees.

"We are probably serving about 2,000 area residents right now," Kane said. "In a year or two when we have a full complement of residents we hope to be providing primary medical care for about 8,000 people."

The clinic operates like a private group medical practice. Each resident spends certain hours in the clinic and is assigned a certain number of families as his private patients. Patients call for appointments just as they would at a private physician's office. The rest of the time the residents spend rotating through various services at Duke and Watts hospitals.

* * *

For the past 20 years, thousands of elderly patients from Europe, Asia, Africa and the United States have flocked to clinics in Bucharest and Constanza, a resort city on the Black Sea, to receive treatments with a controversial Romanian "youth drug"—Gerovital H3.

Now researchers at Duke are conducting one of the first double-blind clinical trials of Gerovital (GH3) in the United States to determine whether it is effective in treating mental depression among the aged.

The study is designed specifically to test the drug for mild to moderate depression, even though Romanian scientists have claimed that by taking the drug the elderly patient can overcome the effects of everything from arthritis and angina pectoris to senility.

The principal investigator on the project is Dr. William W. K. Zung, professor of psychiatry, who is widely known for his research on depression.

Last June Zung visited Professor Ana Aslan, director of the Geriatrics Institute in Bucharest and developer of GH3 therapy, to see how the drug is used there.

Dr. Aslan visited Duke and spoke about her drug at Department of Psychiatry Ground Rounds Feb. 14.

News Notes from the—

BOWMAN GRAY SCHOOL OF MEDICINE WAKE FOREST UNIVERSITY

Dr. Jimmy L. Simon, deputy chairman of pediatrics at the University of Texas Medical Branch in Galveston, has been appointed professor and chairman of the Department of Pediatrics at the Bowman Gray School of Medicine.

He succeeds Dr. Weston M. Kelsey, who asked to be relieved of the chairmanship in order to return to

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Therapy Pack—28 vaginal capsules

CANDEPTIN Vaginal Tablet

Therapy Pack—28 vaginal tablets

Brief Summary

Description: CANDEPTIN (Candididin) Vaginal Ointment contains a dispersion of Candididin powder equivalent to 0.6 mg. per gm. or 0.06% Candididin activity in U.S.P. petrolatum. 3 mg. of Candididin is contained in 5 gm. of ointment or one applicatorful. CANDEPTIN Vaginal Tablets contain Candididin powder equivalent to 3 mg. (0.3%) Candididin activity dispersed in starch, lactose and magnesium stearate.

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Indications: Vaginitis due to *Candida albicans* and other *Candida* species.

Contraindications: Contraindicated for patients known to be sensitive to any of its components. During pregnancy manual Tablet or VAGELETTES Capsule insertion may be preferred since the use of the ointment applicator or tablet inserter may be contraindicated.

Caution: During treatment it is recommended that the patient refrain from sexual intercourse or the husband wear a condom to avoid re-infection.

Adverse Reaction: Clinical reports of sensitization or temporary irritation with CANDEPTIN Vaginal Ointment, Vaginal Tablets or VAGELETTES Vaginal Capsules have been extremely rare.

Dosage: One vaginal applicatorful of CANDEPTIN Ointment or one Vaginal Tablet or one VAGELETTES Vaginal Capsule is inserted high in the vagina twice a day, in the morning and at bedtime, for 14 days. Treatment may be repeated if symptoms persist or reappear.

Available Dosage Forms: CANDEPTIN Vaginal Ointment is supplied in a Patient Therapy Pack, containing two 75 gm. tubes with two applicators for the full course of treatment. CANDEPTIN Vaginal Tablets are packaged in boxes of 28, in foil with inserter—enough for a full course of treatment. CANDEPTIN Vagalettes Vaginal Capsules are packaged in a Patient Therapy Pack, containing 28 CANDEPTIN Vagalettes Vaginal Capsules (2 boxes of 14), for the full course of treatment. Store under refrigeration to insure full potency.

Federal law prohibits dispensing without prescription.

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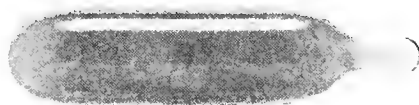
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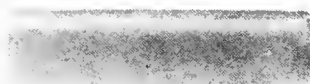
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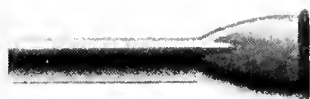
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full-time teaching and patient care. Dr. Kelsey has headed the department for the past 20 years.

Dr. Simon, who is best known for his work in ambulatory pediatric care, cystic fibrosis and medical education, joined the faculty of the University of Texas Medical Branch in 1966 as associate professor and deputy chairman of the department. Earlier he served on the faculty of the University of Oklahoma School of Medicine.

He holds the A.B. degree from the University of California at Berkeley and the M.D. degree from the University of California School of Medicine in San Francisco. He took postdoctoral training at the University of California Hospital, the Grace-New Haven Hospital (New Haven, Conn.) and Children's Hospital (Boston).

* * *

A joint medical center administrative board of the Bowman Gray School of Medicine and North Carolina Baptist Hospital was established recently at the medical center.

The 17-member board has delegated to it by the boards of trustees of the hospital and Wake Forest University responsibility for overall supervision of the medical center. A primary function of the administrative board will be to formulate general policies of the medical center and to provide planning for its future needs and development.

The chairmen of the two boards of trustees, in a joint statement, said that the need for the new organizational structure was evident in view of the medical center's rapid expansion, the growing complexities in managing an academic medical center, and the increased demands being placed on the institutions.

They emphasized that the corporate autonomy and operational integrity of both institutions will be maintained and the establishment of the administrative board will not interfere with nor infringe upon the duties of the trustees of the hospital or the university.

The new board consists of eight representatives of the trustees of Wake Forest University, eight representatives of the trustees of Baptist Hospital, and a member of the professional staff of the medical center.

* * *

Four piedmont North Carolina leaders have been named to the Board of Visitors of the medical school. They are Mrs. Smith Bagley, Winston-Salem housewife and civic leader; Richard T. Chatham of Elkin, president of Chatham Manufacturing Co.; W. Roger Soles of Greensboro, president of Jefferson-Pilot Co.; and J. Paul Sticht of Winston-Salem, president and chief operating officer of R. J. Reynolds Industries, Inc.

* * *

Dr. Irving B. Elkins, a third-year resident in urology, has won first place in the Clinical Research

Division of the Montague Boyd Prize Essay Contest. The contest is sponsored by the Southeastern Section of the American Urological Association.

The award, which carries a \$350 prize, was presented for his essay on "Surgical Anatomy of the Human Kidney."

* * *

The Comprehensive Stroke Program of the medical school has been awarded a \$150,000 grant from the Kate Bitting Reynolds Health Care Trust. It will allow the program to continue its work for the next three years.

The grant will enable the program to continue its followup of stroke patients in the 20 counties where the program operates, to help finance a cooperative effort with the North Carolina Heart Association in fighting stroke, and to train doctors and nurses from small communities in North Carolina to recognize stroke earlier and to provide the latest therapy and rehabilitation to stroke victims.

* * *

Dr. B. Lionel Truscott, professor of anatomy, has been elected to the Executive Committee of the Stroke Council of the American Heart Association as a Member-at-Large.

* * *

Dr. L. Earl Watts, associate professor of medicine, has been inducted as a fellow in the American College of Cardiology.

AMA COUNCIL ON CONSTITUTION AND BYLAWS

The Council on Constitution and Bylaws of the American Medical Association is investigating a proposal to grant to national medical specialty societies direct representation in the AMA House of Delegates. The first objective is to determine whether such representation would be in the best interest of the AMA.

In resolving the first issue, the Council is applying to the members of all state medical societies, AMA delegates, and members of medical specialty societies to share their opinions with regard to the following:

What effect would direct representation of medical specialty societies have on—the Federal concept upon which AMA is based; the Scientific Assembly of the AMA; the membership of all the medical societies involved (the AMA, state, county, and medical specialty societies); and, the activities and influence in the community of the state and county medical societies?

Further questions may be suggested, from then on, to conclude a thorough study. Responses should be addressed to: Council on Constitution and Bylaws, American Medical Association, 535 North Dearborn Street, Chicago, Illinois 60610.

NEW AUDIOVISUAL PRESENTATION ON CURRENT PROCEDURAL TERMINOLOGY

Computer Systems in Medicine has made available a new audiovisual presentation on the 3rd edition of "Current Procedural Terminology." This sound and slide resource is useful in familiarizing physicians with the benefits of CPT-3 usage in their practice.

For further information write to: Computer Systems in Medicine, Division of Medical Practice, American Medical Association, 535 North Dearborn Street, Chicago, Illinois 60610.

TENNIS TOURNAMENT AT 1974 ANNUAL MEETING OF THE NORTH CAROLINA MEDICAL SOCIETY

The North Carolina State Medical Meeting in Pinehurst, N. C., May 18-22, 1974, will hold a tennis tournament having equal billing with the usual golf tournament. Depending on the number of entries, the program will include open men's singles, men's doubles, senior men's singles, and men's doubles; women's singles, women's doubles and mixed doubles. Each person will be permitted to enter no more than three events.

Inquiries and notification of class entries should be addressed to: Claude A. Frazier, M.D., 4-C Doctor's Park, Asheville, N. C. 28801.

Month in Washington

The American Medical Association has announced the filing of a law suit against the Cost of Living Council to seek an end to all economic controls on medicine.

At a news conference in the AMA-Washington office, the organization disclosed that it is seeking an injunction against the Phase IV regulations on physicians and hospitals. It charged that the rules are confiscatory, arbitrary and capricious," that they violate the "generally fair and equitable" standard established by Congress and that they violate the fifth amendment of the U.S. Constitution.

Announcement of the legal action was made by Russell B. Roth, M.D., President of the AMA, and James H. Sammons, M.D., Chairman of the AMA Board of Trustees.

In its complaint stating its legal action, the AMA pointed out that the Phase IV regulations represent "an attempt to mold the health care delivery system to comport with the CLC's concepts for health care" and are specifically designed "to curb the quantity and quality of health care services as an integral part of the legislative program to induce Congress to enact national health insurance."

The AMA asked that the court declare these Phase IV regulations invalid and enjoin the Cost of Living Council from enforcing them.

In his statement, Dr. Roth said the AMA was filing in U.S. District Court, District of Columbia, a suit seeking an injunction against the Cost of Living Council. "We are asking the court to declare invalid the Phase IV regulations as applied to physicians

and hospitals on the grounds that they are confiscatory, arbitrary, capricious and discriminatory.

"We further believe that they violate the very law on which they are based in that they do not conform to the 'generally fair and equitable' standard written into the law by the Congress.

"Finally, we believe that they violate the most fundamental law of the land—the Constitution of the United States, in that they confiscate the property of physicians and hospitals without due process of law, a clear infringement of the fifth amendment.

"Those are the legal tenets on which we are basing our case. We are convinced that they are valid and sound and that they will prevail in the courts.

"But while we proceed on legal grounds, I think it is important to point out that we believe the issues involved are far broader than mere legalisms and that they cast their shadows far beyond the limited scope of Phase IV.

"They are issues of principle and they have profound implications for the future of health care in this country.

"... It is patently unfair and unreasonable for the services of some working people—namely us physicians—to be subject to severe price controls while permitting other working people to function in a free market. That is not fair play; it is an act of discrimination.

"It is patently unfair to apply a revenue margin limitation to physicians in private practice so that they are penalized if they work longer hours and see more patients. That is not fair play; it is an act of

capriciousness—not to mention that it is also shortsighted as hell.

"It is patently unfair when physicians are subject to controls but chiropractors and naturopaths are not . . . when ophthalmologists are subject to controls but optometrists and opticians are not . . . when psychiatrists are subject to controls but clinical psychologists and psychiatric social workers are not. That is not fair play; rather it is an act so arbitrary as to be vindictive.

"Any one of these would be good and sufficient reason to end the controls, in and of itself. For a law that is applied arbitrarily, capriciously and vindictively is a bad law and ought to be abolished.

"But there are even more compelling reasons why the controls should be abolished—not just from health care but from the entire economy.

"Perhaps the best reason for getting rid of them is that they just don't work. . . ."

Dr. Sammons' statement noted that the AMA did not stand alone in its call for an end to all controls. "No less a person than C. Jackson Grayson—chairman of the Price Commission during Phase II—has adopted the same stance," Dr. Sammons said, adding "he has been echoed by the Wall Street Journal and others."

"In the face of this advice and the evidence that controls don't work, why does the Cost of Living Council persist in continuing the controls?

"CLC officials have made no secret of the fact that they intend to control far more than costs in the health care field through their regulations. The press release from the CLC announcing Phase IV established these goals:

"reduce the inflationary rate of increase in the cost of hospital stay;

"provide economic incentives for the substitution of less expensive ambulatory care in place of inpatient hospital care where possible;

"maximize internal flexibility and incentives for health care managers to improve productivity;

"be responsive to cost saving innovations, such as health maintenance organizations and prospective reimbursement plans. . . ."

"Further, to enforce the last of these goals, the Phase IV regulations were drawn to confer outright favoritism on physicians under contract with an HMO. They have been exempted from the revenue margin limitation that is applied to physicians in private practice.

"This is not economic stabilization. This is not inflation control.

"This is nothing less than a blatant attempt by the social schemers at CLC to impose their will on the physicians and patients of America.

"What right have they to tell us how to practice medicine?

"What right have they to tell the American people where and how they shall receive their medical care?"

"These are *not* economic controls . . . they are political controls. We intend to fight them right down the line. . . ."

"We recognize how appealing it is to try—through controls—to keep the lid on at least some costs during this period of astronomical inflation. We certainly recognize and are sensitive to the plight of the great majority of wage earners who have been caught in this terrible squeeze. We have tried to do our share to keep costs down.

"Since the beginning of Phase I in August 1971, physicians' fees have risen but 7.3 per cent while the cost of living generally has risen by 13.3 per cent and legal fees, by contrast, have risen by 26 per cent.

"We have cooperated—the figures prove that. But now the time has come to call a halt.

"For the simple truth is that unless the controls are removed—and soon—the quality of health care—particularly in the hospitals—is going to suffer.

". . . And that is precisely what is going to happen very soon if the controls continue.

"We believe the American people had better know and understand that."

* * *

One day after the AMA filed its suit against the Cost of Living Council, President Nixon reaffirmed the Administration's intention to keep cost controls on hospitals and physicians until a national health insurance program is approved.

In a second message on health submitted to Congress, the President also emphasized a shift in policy on health education from operating subsidies to direct assistance to students. Nixon said "The nation's total supply of health professionals is becoming sufficient to meet our needs during the next decade. In fact, oversupply in the aggregate could possibly become a problem."

On controlling health costs, the President said, "We must avoid the cost inflation which followed the introduction of Medicare and Medicaid. Our health insurance proposal would call for states to oversee the operation of insurance carriers and establish sound procedure for cost control. Until these and other controls are in place, I recommend that our present authorities to control health care costs be continued. I am asking the Congress for such authority." Inflationary pressures are still strong in the medical field, he said, "so that we must maintain federal controls until other measures are adopted under comprehensive health insurance."

* * *

Shortly after an AMA delegation met separately with President Nixon and Health, Education, and Welfare Department Secretary Casper Weinberger, the latter announced he would drop the hotly contested proposed regulations that would have required pre-admission certification for the hospitalization of Medicare and Medicaid patients.

The President had assured the AMA delegation

lier in the day that serious consideration would be given to changing the controversial pre-admission certification plan.

Those visiting the President were Russell Roth, M.D., AMA President; James Sammons, M.D., Chairman of the AMA Board of Trustees; Malcolm Dodd, M.D., AMA President-elect; Ernest B. Howland, M.D., AMA Executive Vice President, and Joseph Miller, Assistant Executive Vice President.

Other topics discussed by the President and the AMA group included the Administration's plan for nationwide fee schedules in its national health insurance proposal and area designations for Professional Standards Review Organizations (PSRO's).

The AMA delegation told the President of their strong opposition to the pre-admission certification plan as an unwarranted interference with medical and hospital judgments; contended that continuation of controls on physicians would be unfair and punitive; declared that fee schedules in an NHI program would be government regimentation; and suggested that the PSRO program needed regrouping and a new start after encountering stiff resistance from physician groups and much controversy and confusion.

The Chief Executive, according to participants, warmly received the delegation and declared that he was aware of the problems physicians face in the area of expanded federal supervision. President Nixon indicated that serious consideration would be

given to changing the requirement of area or statewide fee schedules in his NHI plan. He stressed that he wished to avoid saddling physicians with unnecessary paperwork that would take time away from patient care.

The President also talked of his desire that high level quality care be maintained. Physicians should work for patients and not the federal government, he told the delegation. He outlined his NHI program and his opposition to a bill of the scope of the Labor-Kennedy plan.

Conceding that the Administration's programs might well be amended by Congress, he invited the AMA to recommend changes in the NHI program.

* * *

The federal government will spend more than \$26 billion next fiscal year on civilian health programs if the Administration's proposed budget is approved by Congress.

The budget reflects the Administration's desire to hold health spending in the fiscal year that begins July 1 to about the level Congress approved for the current fiscal year, considerably more than requested. The exception is an unavoidable \$3 billion hike in Medicare and Medicaid outlays.

The new health budget is almost \$8 billion over the spending in the fiscal year 1973 that ended last June.

HEW Secretary Caspar Weinberger conceded that

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the budget reflects "in a number of ways the results of that give and take" involved in the battle with Congress last year over HEW appropriations.

No funds are sought for the Administration's new national health insurance program, even if Congress acted this year, Weinberger noted, and it would take another year or longer to gear up for the program which carries a \$5.8 billion price tag.

The budget emphasized two controversial HEW

programs of special interest to the medical profession. To carry out the Health Maintenance Organization (HMO) program, \$65 million was recommended for the remainder of this fiscal year, and \$65 million for next year. The Professional Standards Review Organization (PSRO) program was cut down for \$34 million through the remainder of the current fiscal year; \$58 million, next year.

Those who wish for the cure of an obstinate malady from the mineral waters, ought to take them in such a manner as hardly to produce any effect whatever on the bowels. With this view a half-pint glass may be drank at bed-time, and the same quantity an hour before breakfast, dinner, and supper. The dose, however, must vary according to circumstances. Even the quantity mentioned above will purge some persons, while others will drink twice as much without being in the least moved by it. Its operation on the bowels is the only standard for using the water as an alterative.—*William Buchan: Domestic Medicine, or a Treatise on the Prevention and Cure of Diseases by Regimen and Simple Medicines, etc., Richard Folwell, 1799, p. 431.*



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Book Reviews

Current Diagnosis and Treatment. By Marcus Krupp, M.D. and Milton J. Chatton, M.D. Price, \$12.00. Los Altos, California: Lange Medical Publications, 1973.

This most recent edition of *Current Diagnosis and Treatment* is, once again, larger and more expensive than its predecessor. Despite the shortcomings always present in condensed surveys of vast and varied textbooks of medicine, this paperback does serve the authors' stated purposes. "It is not intended to be used as a textbook of medicine. . . is intended to serve the practicing physician as a useful desk reference on readily accepted technics currently available for diagnosis and treatment"—these general aims are met in most instances.

The text is characterized by a huge array of specific disease entities and each is headed by a succinct summary of "essentials of diagnosis." References are plentiful and generally up-to-date. The format of the text is largely founded on a pathologic basis; thus, the interested physician or student, or both, must have made a reasonably accurate prior diagnosis if he is to use this book as a clinical "practice" aid. The book serves as a basis of review and should be rewarding for the physician and student undertaking such a project. Many of the contributors have made significant contributions to other Lange publications, and discussions of therapy often closely simulate, if not duplicate, discussions in some of these (e.g. *Review of Medical Pharmacology*). The text could not be considered an "emergency" type of reference, but rather a handy source to check the essential diagnostic and therapeutic aims for a given condition.

Despite these stated drawbacks, the amount of information per dollar spent, represented by this text, is difficult to surpass. Perhaps its greatest strength

lies in the fact that it is *rewritten yearly* and in a meaningful manner.

JOHN S. KAUFMANN, M.D., PH.D.

Annual Review of Allergy, 1972. Claude A. Frazier, M.D., (ed). Price, \$12.00. Flushing, New York: Medical Examination Publishing Company, Inc., 1973.

The purpose of the *Annual Review of Allergy*, according to the editor's preface, "is to bring together in one volume the most important. . . recent advances" in this field from the previous year. There is a need for such a book, particularly for the practicing allergist, because of the explosion of new knowledge in the areas of allergy and clinical immunology.

In order to serve this purpose, the book should be short, the writing style should be succinct, and the sections should not overlap. A standard format, utilized in all chapters, would be desirable and duplication should be eliminated by the editor. The format used in Section IV is excellent and could well be adapted to other sections. Suggested section headings for future volumes are: Basic Mechanisms in Allergic Disease, Asthma, Non-Asthmatic Allergic Lung Disease, Ocular Allergy, ENT Allergy, Allergic Skin Diseases, Insect Allergy, Drug Allergy, Aerobiology, Treatment with Pharmacologic Agents (including steroids), Immunotherapy (including the current status of bacterial vaccines) and Rehabilitation (including psychological factors). Despite its defects (excessive length, lack of a standard format, and overlapping of subject headings with resulting repetition), this book is a step in the right direction.

The chapter on Aerobiology was of particular interest to this reviewer.

CAROLYN C. HUNTLEY, M.D.

The instruments of medicine will always be multiplied in proportion to men's ignorance of the nature and cause of diseases: when these are sufficiently understood, the method of cure will be simple and obvious.—*William Buchan: Domestic Medicine, or a Treatise on the Prevention and Cure of Diseases by Regimen and Simple Medicines, etc., Richard Folwell, 1799, p. 437.*

In Memoriam

Weldon Parten Chandler, M.D.

Weldon Parten Chandler died on April 11, 1973 after a long illness. He was 57 years old.

A native of Asheville and Buncombe County, he practiced in Weaverville, N. C. from 1946 until his retirement several years ago because of illness.

He was educated in the Asheville public schools, Mars Hill College, Wake Forest College, and received his M.D. Degree from the University of Maryland in 1940. His internship was at Baptist Hospital, Winston-Salem, N. C.

He was a member of the Buncombe County Medical Society, Madison County Medical Society, and the North Carolina State Medical Society. He was also a member of Phi-Rho Sigma Fraternity, Lions Club, and Masons.

Weldon was distinguished by his skill as a doctor and compassionate concern for his patients' welfare, overriding any concern for himself. He was greatly loved and respected by his patients and colleagues.

Whereas, Dr. Chandler was a skilled and dedicated physician, much loved and respected, be it

RESOLVED, That a copy of this resolution be sent to his widow, Athylene Briggs Chandler, a copy to be incorporated in the minutes of the Buncombe County Medical Society and a copy forwarded to the North Carolina Medical Society for publication in the State Journal.

BUNCOMBE COUNTY MEDICAL SOCIETY

Edgar Witherly Lyda, M.D.

Ed Lyda died June 11, 1973 at the age of 52. He practiced obstetrics and gynecology for many years in Asheville, until recently becoming Assistant Director of the Buncombe County Health Department. In the latter position he was active in Family Planning Programs.

He was an Asheville native, a graduate of Mars Hill College, Wake Forest College, and Bowman Gray School of Medicine, graduating from the latter in 1944. His internship was at the Baptist Hospital, Winston-Salem, N. C., and three years in residency in St. Louis.

He was a Diplomate of the American Board of Obstetrics and Gynecology. He served three years in the U. S. Navy Medical Corps and attained the rank of Lieutenant Commander.

Dr. Lyda is survived by his wife, the former Emily

Katherine Perkinson, four children and by his parents, Mr. and Mrs. William C. Lyda of Raleigh.

Dr. Lyda had a keen mind and was sharply analytical. He had a warm personality and carried a high degree of competence and dedication into his practice.

Whereas, Ed Lyda has left us prematurely and his passing is a great loss to the profession, be it

RESOLVED, That this brief and paltry account be transcribed and registered in the minutes of the Buncombe County Medical Society, a copy sent to his widow and to his parents and one to the Journal of the North Carolina Medical Society for publication.

BUNCOMBE COUNTY MEDICAL SOCIETY

Joseph Franklin Hamilton, Jr., M.D.

Joe Frank Hamilton died on May 5, 1973 at the age of 45 after a long battle with cancer. In spite of increasing illness, he continued to practice orthopedics until a few months before his death.

He was associated with the Asheville Orthopedic Associates since 1958. He was a member of the local and state societies and several orthopedic associations. In addition, he was a fellow of the American Academy of Orthopedic Surgeons.

Dr. Hamilton was a native of Memphis. He received his M.D. from Tulane in 1953, and did his internship at Charity Hospital in New Orleans. He was in general surgery for a year at Baptist Hospital in Memphis before joining Campbell Clinic in the same city where he remained for three years.

He is survived by his three children, Miss Jo Lyn Hamilton, Claude, and Joseph and by his father, Dr. Joseph Franklin Hamilton, Sr. His wife, Mrs. Anne Motley Hamilton, died in 1971.

Joe Frank was a greatly respected physician, not only for his skill in medicine but also for his devotion to his church and for his magnificent courage and fortitude in the face of much personal tragedy.

Whereas, Joe Frank was an outstanding physician and will be sorely missed by his colleagues in the Society and by his patients, be it

RESOLVED, That a copy of this writing be forwarded to the Journal of North Carolina Medical Society for publication, a copy to be incorporated in the minutes of the Buncombe County Medical Society and a copy sent to the bereaved family.

BUNCOMBE COUNTY MEDICAL SOCIETY

NORTH CAROLINA

Medical Journal

IN THIS ISSUE: Congenital Neuroblastoma Presenting as Hydrops Fetalis, Archie T. Johnson, Jr., M.D. and LDCR David Halbert, M.D.; The Present Status of the Physician's Assistant Program of the Bowman Gray School of Medicine, Hal T. Wilson, M.D.; Cystosarcoma Phylloides in a Twelve-Year-Old Girl, James M. Kelsh, M.D.; Doctor, What Did You Say? Hugh A. Matthews, M.D.



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medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard



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Congenital Neuroblastoma Presenting as Hydrops Fetalis

Archie T. Johnson, Jr., M.D.* and LDCR David Halbert, M.D., MC USN†

REPORT OF A CASE

THE patient was a 3,000 gm infant girl born to an 18-year-old primigravida after a 36-week gestation. The mother's blood type was O negative and her anti-Rh₀ titers during her uncomplicated pregnancy had been negative. Her membranes ruptured one hour prior to the delivery, and the amniotic fluid was meconium stained. There were no spontaneous respirations or heart sounds, and immediate resuscitation with endotracheal intubation was carried out.

The infant appeared pale and extremely hydropic. The placenta was stained with meconium and appeared to be hydropic. A grade 3/4 systolic murmur was detected along the left sternal border, and rales were heard throughout both anterior and posterior lung fields. The abdomen was tense and edematous. The liver and spleen were enlarged to the umbilical crest.

The patient was thought to have hydrops fetalis, and immediate exchange transfusion was carried out with fresh O negative packed cells.

The initial central venous pressure was 25 cm of water. Initially, approximately 55 ml of blood was removed and the CVP decreased to 15 cm of water. After the first exchange transfusion, a total of 405 ml of blood was removed and a total of 300 ml of packed cells was used as a replacement. The CVP after the exchange was 11 cm of water and the hematocrit reading was 44 percent. When laboratory data became available, the cord hematocrit reading was 19 percent and the total bilirubin level was 2 mg/dl. The baby's blood type was B negative and the Coomb's test was negative. The bilirubin level did not rise above 2 mg/dl during the patient's subsequent course. Serum electrolytes remained normal, and the patient appeared to improve after this procedure. A flat film of the abdomen revealed a homogeneous mass in the right upper quadrant. During the next 24 hours, the patient's CVP rose to 17 cm of water and the hematocrit value dropped to 25 percent. Intermittently, phlebotomy and replacement with packed cells were performed. An effort was made to keep the CVP at approximately 10 cm of water and the hematocrit level at approximately 40 percent. The infant was extremely acidotic

and was treated intermittently with sodium bicarbonate.

The diagnosis remained obscure. On the second day in the hospital the patient had a cardiac arrest and died.

Pathological findings

The 1,045 gm placenta measured 21 x 21 x 4 cm. The umbilical cord was connected paracentrally and contained two arteries and one vein. All the cotyledons were on the maternal surface. No gross abnormalities were present. Microscopically determined, there was good vascularization of the chorionic villi. The villi were covered by a single trophoblast. The capillaries contained numerous nucleated red cells and a few blast cells. In addition, there were nests of uniformly round to oval neuroblastoma cells which contained hyperchromatic nuclei and scant pink cytoplasm (Figure 1).

The main autopsy (A-70-89) findings were as follows: Neuroblastoma involving the adrenal glands, liver, lungs, and the brain; severe acute pulmonary hyperemia and hyaline membrane formation.

The infant was 43 cm long and weighed 2,879 gm. There was moderate generalized edema of the scalp,

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†Present address: 11805 Hitching Post Lane, Beltsville, Maryland.
Reprint requests to Dr. Johnson.

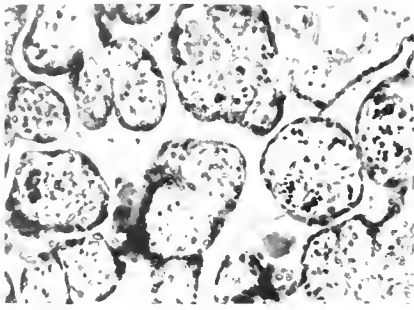


Fig. 1. Neuroblastoma cells in placental villi. (H & E, x 250.)

chest, genitalia, and extremities. The abdomen was protuberant. The massive liver (Figure 2) weighed 358 gm (normal, 78 gm) and was reddish-brown, studded with numerous 0.5-1 cm white nodules having depressed centers. These nodules replaced approximately 80 percent of the hepatic parenchyma. The 33.3 gm (normal, 9.8 gm) left adrenal was replaced by a well-encapsulated, soft brown mass with a smooth capsular surface; it measured 4.5 x 2.5 x 4 cm. The cut surface of this mass was soft and reddish-brown with yellow streaks. The 1.3 gm right adrenal had hemorrhage in the medulla. Except for a patent foramen ovale, the cardiovascular system was normal. Both lungs were edematous with slight crepitation. The spleen weighed 6.74 gm (normal, 8 gm). A small Meckel's diverticulum was present. The brain weighing 400 gm (normal, 335 gm) was very soft. Small areas of subarachnoid hemorrhages were in the left frontal lobe and a more extensive hemorrhage was around the brain stem.

Microscopic examination showed

the mass in the left adrenal to be composed of large sheets and nests of small cells which contained large, round to oval, hyperchromatic nuclei with scant pink cytoplasm. The cells were loosely arranged in a reticular stroma. The sheet of cells was separated by delicate, vascular fibrous tissue. Areas of necrosis were prominent (Figures 3 and 4). Small amounts of adrenal tissues were compressed toward the periphery of the mass which was also infiltrated by nests of tumor cells. These tumor cells infiltrated the right adrenal, the pancreas, and the liver. The tumor cells were present in the blood vessels of the lungs and brain. No infiltration of these latter organs was seen. Severe acute passive hyperemia was present in both lungs, kidneys, and spleen. The lungs showed areas of hyaline membrane formation.

COMMENT

In 1892, Ballantyne,¹ collected from the literature 65 case reports of fetal edema. Among this series were cases of congenital cardiac defects, polycystic kidneys, syphilis, and leukemia. Ballantyne recognized that hydrops is a sequel of varying disease processes. In 1943 Potter² reported 13 cases of severe hydrops without erythroblastosis fetalis; she reported four other cases of fetal hydrops, but these presented with gross congenital anomalies, and she made the point that hydrops was not a specific disease but a symptom common to several diseases.

In erythroblastosis fetalis, the pathogenesis of hydrops fetalis is related to isoimmunization (of the Rh-

mother's anti-Rh agglutinins against her Rh+ infant's red cells). The antibodies cross the placenta into the fetal circulation, producing a hemolytic state. If the infant's erythropoietic tissue cannot compensate for the increased hemolytic rate, an intrauterine anemia develops. When anemia becomes severe, cardiac compensation may occur with resultant hypoxemia, metabolic acidosis, and massive anasarca.

Potter³ has described fetal hydrops in children whose mothers had toxemia, nephritis, or other chronic diseases. Hydrops fetalis, secondary to ABO incompatibility, is extremely rare but has been detected. In the literature are several case reports of lutein cysts of the ovaries and one case of congenital cystic and adenomatoid malformation of the lung associated with hydrops.⁴

In 1964 Strauss and Driscoll⁵ reported two cases of congenital neuroblastoma involving the placenta and presenting with hydrops. These authors postulate that obstruction to the venous return by a huge intraabdominal mass and a tumor in the hepatic and placental vascular channels may have played a part in the pathogenesis of the hydrops. Gottschalk and Abrams⁶ have postulated a similar mechanism to explain the placental edema of fetal hydrops associated with other congenital tumors causing compression of the vena cava and resulting in mechanical obstruction of the venous return to the heart. The anemia in this case is postulated to be caused by the invasion of tumor cells into the erythropoietic tissue.



Fig. 2. Liver (in situ) which is massively enlarged by round, white nodules.

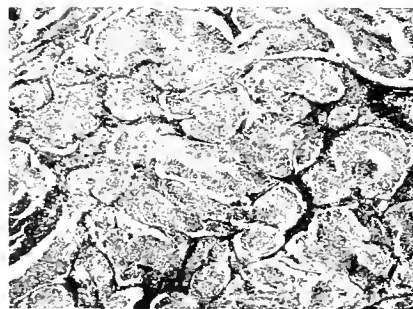


Fig. 3. Adrenal gland containing neuroblastoma cells. (H & E, x 40.)

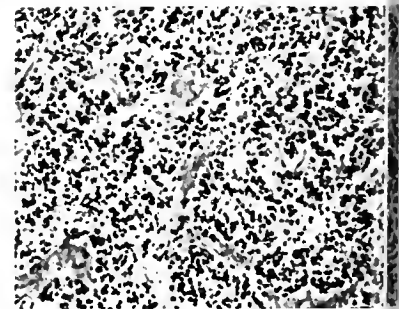


Fig. 4. Increased magnification of adrenal gland showing neuroblastoma cells. (H & E, x 250.)

Edema occurs in most types of severe fetal anemia, as in cases of transplacental transfusion between monochorial twins, hemolysis, chronic infections, or chronic fetomaternal bleeding. The cause of the edema is not clear, but certainly obstruction to the venous return to the right side of the heart by the huge liver, as shown in Figure 2, is probably a major contributing factor.

SUMMARY

Hydrops fetalis is often viewed as a specific feature of Rh incompatibility. However, hydrops fetalis may be associated with conditions other than Rh incompatibility, as is shown in the present case in which a congenital neuroblastoma was the underlying malady. The case is of additional general interest in that involvement of the placenta by neuroblastoma was documented.

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The great variety of forms into which almost every article of medicine has been manufactured, affords another proof of the imperfection of the medical art. A drug which is perhaps most efficacious in the simplest form in which it can be administered, has been nevertheless served up in so many different shapes, that one would be induced to think the whole art of physic lay in exhibiting medicine under as many different modes as possible.—*William Buchan: Domestic Medicine, or a Treatise on the Prevention and Cure of Diseases by Regimen and Simple Medicines, etc., Richard Folwell, 1799, p. 437.*

The Present Status of the Physician's Assistant Program of the Bowman Gray School of Medicine

Hal T. Wilson, M.D.*

THE Physician's Assistant Program began in North Carolina in 1965 under the guidance of Dr. Eugene Stead at Duke University. Since that time few assistants have been produced by ongoing programs. As far as can be determined, there are 800 physician's assistants of all types across the nation.¹ There are approximately 39 approved programs¹ which train "assistants to the primary care physician" as outlined by the Joint Review Committee for the American Medical Association.² Nearly 500 physician's assistants of this type are at work.

Physician's assistants have become part of the usual scene at the Bowman Gray School of Medicine and Medical Center. In our two-year training program, now in its sixth year, we have 50 students in the first and second year classes; 38 graduates from our program are working in physicians' offices.

Our program has produced assistants to the primary care physician (pediatricians, internists, and family practitioners) with the exceptions of one each to a psychiatrist, a surgeon, and an obstetrician.

The official definition of the assis-

tant to the primary care physician is as follows: "A skilled person, qualified by academic and clinical training to provide patient services under the supervision and responsibility of a doctor of medicine."³ In 1969 Dr. Leland Powers and Dr. Robert Howard forecast, in a survey by the Duke Bowman Gray Schools of Medicine, the professional acceptance of physician's assistants.⁴ Of the 3,800 questionnaires sent to physicians, 2,025 were answered. Of the physicians who replied, 1,660 (82 percent) said they were ready to accept the concept of the physician's assistant, and 700 indicated that they would employ physician's assistants if they could get them. Today, graduates from both programs are eagerly sought; they are having no difficulty in gaining employment.⁵

The purpose of these programs is to make available "physician expanders" who, by providing many clinical functions, save time for the physician so that he can more adequately serve his patients. In the ideal situation the physician can briefly verify the high points of the health history and the physical examination data obtained by the physician's assistant. The physician must agree with the assistant's identification of the patient's problems and decide or approve all diagnostic

and treatment plans. The physician assistant also may assist counseling when appropriate.

This broad view of the role of physician's assistants is not necessarily the prevailing opinion. Some physicians view the role of the physician's assistant as that of a technician; others think the physician assistant should have the responsibility for participating in all medical activities including the initial evaluation of the patient and the design of the treatment plan.

Our concept at Bowman Gray follows the guidelines originally defined by the National Academy of Sciences which depict the "Class A" physician's assistant as "one who corresponds with the highest level of allied health workers" and who is distinguished by his "ability to integrate and interpret medical findings on the basis of general medical knowledge and to exercise a degree of independent judgment."⁶ The physician's assistant will also "assist in gathering the data necessary to reach decisions in implementing the therapeutic plan for the patient."³

Our initial dilemma concerns decisions as to curriculum. We await a sound evaluation of various physician's assistant roles in medical practice and suggestions from those who work with the graduates of c-

* Medical Director, Physician's Assistant Program, Division of Allied Health Programs, Bowman Gray School of Medicine of Wake Forest University, Winston-Salem, North Carolina 27103.

ing programs. Braun⁷ of Duke as well as others) has done task evaluations of physician's assistants office activities. Here, too, at Bowman Gray, evaluations have been initiated. Those North Carolina physicians who employ our physician's assistants seem to be exceedingly tolerant of our incursions into their offices and our efforts to measure the results of the working relationship with physician's assistants. However, the number of practices evaluated is still insufficient to help us in curriculum design. Another dilemma for the curriculum designer arises in regard to the utilization of physician's assistants in medical practice.

We hope the physician's assistant to graduates from our program will be a first-class data base gatherer: He does a complete history when necessary; his information is pertinent; he has the ability to understand both the organic and nonorganic problems as well as the environmental, social, and economic factors involved in a patient's illness and problems. To obtain an adequate and viable history, the physician's assistant must use some degree of clinical judgment. We concur with the American Medical Association's description: "Instruction should be sufficiently comprehensive so as to provide the graduate with an understanding of mental and physical disease . . . to provide . . . technical capabilities, behavioral characteristics and judgment necessary to perform in a professional capacity all of his assignments."³

Viewing our responsibilities in the program, we emphasize various capacities that we consider necessary for good patient evaluation (including clinical judgment) rather than follow a purely task-oriented program which would prepare one only for the work of a technician. Of course we recognize that the physician's assistant who does tasks of a technical nature is also saving the physician's time.

Furthermore, consideration of the following occupational guidelines further fortified us in our belief —

A physician's assistant will be able to do the following:

1. Elicit a detailed and accurate history, perform an appropriate physical examination, and record and present pertinent data in a meaningful manner.

2. Perform or choose the required routine laboratory evaluations.

3. Immunize, suture, and handle other routine therapeutic procedures.

4. Instruct and counsel regarding both physical and mental health.

5. Assist in hospital rounds, write progress notes, transcribe orders, and prepare case summaries.

6. Assist in the delivery of services to patients in all settings.

7. Perform independently the evaluation and treatment in emergencies.

8. Be aware of community facilities and resources.³

We think it is important that clinical judgment be involved in many of the physician's assistant's responsibilities as a physician expander. We are concerned with his ability to learn and to apply basic information about the body, in health and in illness, so that the assistant can conceptualize the patient's particular situation as the story unfolds. With the physician's approval, the physician's assistant may handle all the talk, touch, and task activities necessary to problem delineation; he also may use general knowledge specifically applied to the patient in counseling activity.

In the first year, our physician's assistant trainees receive a basic science continuum which is coordinated internally and linked to clinical topics which have two predominating overtones. These units demonstrate basic physiological and pathophysiological modules and represent the most frequently encountered complaints and symptom complexes confronted in primary medical care. We rely on the hospital setting for basic exposure to examples of system function and failure; the outpatient situation provides experience with the more frequently seen clinical entities.

The concern of utilizing the phy-

sician's assistants in medical practice relates to the busy practicing physician, his confidence in the abilities of his assistant, and his own sense of responsibility. Finally, the degree of independence the physician allows his assistant is entirely the decision of the employing physician. The most time-consuming activity in primary care is listening to and examining the patient to produce a careful delineation of his problems. The site of our emphasis should be at this point in primary care activity. Principles of treatment procedures will be learned, but application will vary with the physician and practice concerned.

Independent function of the physician's assistant is likely to occur under many circumstances. According to Estes, "This type of assistant should be allowed to perform in settings apart from the direct supervision of the physician provided the limits of his autonomous activity are clearly defined. . . . The physician need not be present at each activity of the assistant nor be specifically consulted before each delegated task is performed."⁸ Considering these circumstances, we have asked ourselves: What should physician's assistants try to learn? How much of the natural history of disease and basic pathophysiology should be presented? We believe the answer to these questions is: Of the most frequently encountered problems in primary care, they should learn as much as possible.^{9, 10}

We have included in our nine-month basic science continuum early patient encounters and the pharmacology of the chief therapeutic agents. We have not concentrated on routine "cookbook" diagnoses, standing orders, or routine therapies. During his rotation in the hospital and outpatient department during a one-year period, the student is asked to demonstrate that he has learned the natural history of predominant clinical entities in primary medical care and to compile counseling data for indicated clinical problems. Finally, he is tested and evaluated in two 6 to 8 week pre-

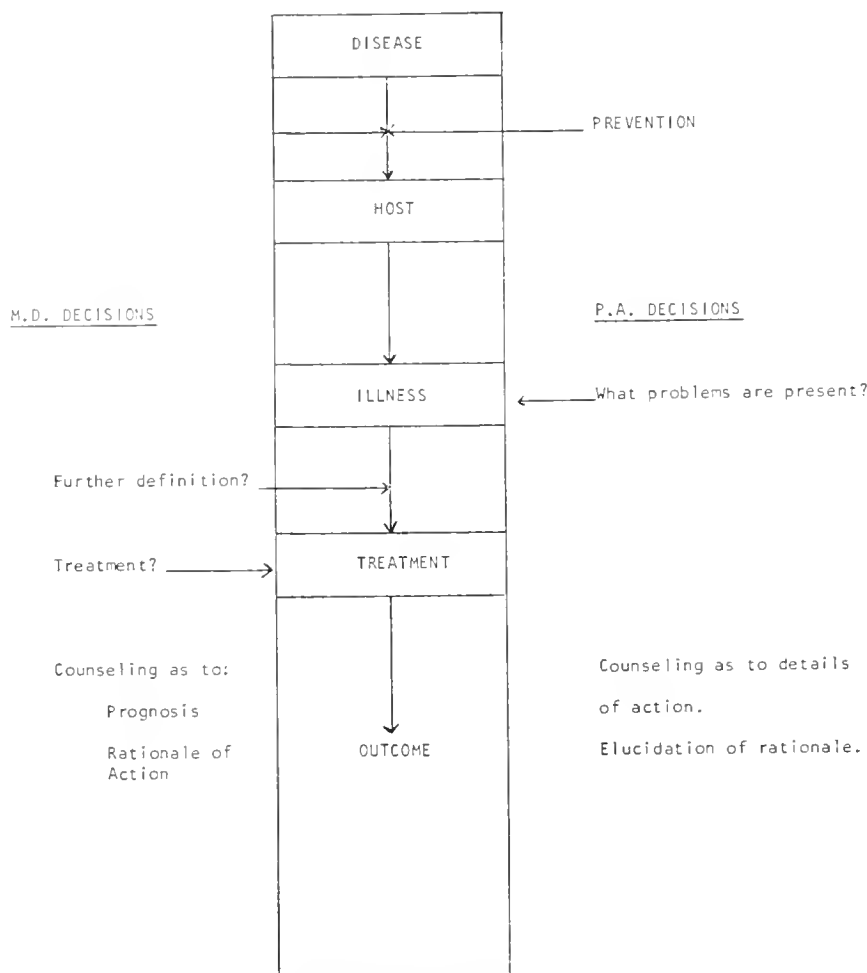


Fig. 1. After Feinstein¹¹

ceptorships with practicing primary physicians.

Bearing in mind the "dangers of a little knowledge" and the authoritative certainty of some people who have a superficial acquaintanceship with medicine, our concern is that the student should be exposed to the extent and complexity of the data needed and should be taught the steps in interrogation necessary to identify problems and make medical decisions. He must develop a sense of humility in the face of the task and a clear and honest recognition of his limitations in knowledge and ability.

According to Feinstein,¹¹ clinical judgment is composed of valid evidence, logical analysis, and demonstrable proof. The physician's assistant who is best qualified to save time for the physician goes as far along the continuum of problem de-

lineation as possible. When an illness begins with an interaction between the disease and the host, the physician's assistant must take an accurate and sensitive view of the patient's social and economic situation as the assistant continues the thorough investigation of the patient's symptoms and signs to that final analysis of data and discernment of problems (Figure 1).¹¹ Resolution of the dilemmas in our educational effort can come only from continuing evaluation of our students' performance and repeated restructuring of the curriculum. Perhaps schools of allied health will allow more opportunity for a true identification of better ways of learning medical knowledge and redefining course content. The system should include process evaluations such as testing the assistant's ability to learn that which saves the physi-

cian time and increases the number of units of health care performed - enhances office economy and patient satisfaction. However, the ultimate test involves the quality of medical care that is maintained or improved with the addition of the physician's assistant to medical practice. Are the objectives of accessibility, care, continuity of care, optimum medical diagnosis and treatment, including preventive and rehabilitative activities, being carried out in such way as to produce more effective medical service?

The challenge of measurement of such end objectives has seldom been met in medical care activities. The Osler Peterson study,⁹ emanating from the University of North Carolina Medical Center nearly 20 years ago, and its companion study, the Canadian Clute Report,¹⁰ painstakingly evaluate practice activities of primary physicians' offices. Even there, medical care processes were evaluated in the practices of only a few physicians. I believe it is possible that the new organizational situation exemplified by the schools of allied health, with their limited constraints and shorter courses, can bring about definitive and exciting studies of pedagogy in medicine and its relation to the effectiveness of patient care.

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Cystosarcoma Phylloides in a Twelve-Year-Old Girl

James M. Kelsh, M.D., F.A.C.S.

SOME confusion in terminology is found in the literature pertaining to breast tumors in adolescent girls. The giant fibroadenoma of this age group presents a problem both in clinical evaluation and surgical approach to anyone not familiar with the characteristics of this tumor. It is not necessary to stress that a radical procedure on a young girl could be avoided, if at all possible. According to Hines and Geurkink, "The giant fibroadenoma is the most common cause of massive enlargement of one breast in the young female patient and cystosarcoma phylloides the second most common."¹ Nevertheless, these tumors are infrequent in children, and the very few that rapidly achieve great size are alarming to the patient and often the attending physician.

Eight cases of cystosarcoma phylloides in girls aged 13 years or less have been reported by the Mayo Clinic²; two of them (Simpson and Lynn) were from the Mayo Clinic itself. Simpson and Lynn do not attempt to distinguish between giant fibroadenoma and benign cystosarcoma phylloides in adolescents.

Recently a case of cystosarcoma phylloides in a 12-year-old girl was encountered at the Tarboro Clinic.

CASE REPORT

A 12-year-old Negro girl was referred to the Tarboro Clinic with the chief complaint of massive enlargement of the left breast over a two-month period. Normal development began one year before admission, and there was no discrepancy in size at that time. Although the left breast began to enlarge two months prior to her clinic visit, the patient dates the sudden increase in size to a blow she received on the school grounds two weeks previously. She denied feeling any pain in the breast, but complained of a sensation of numbness.

The menarche had not yet occurred in this patient; the medical and family history were otherwise unremarkable.

The physical examination disclosed no abnormalities, with the exception of the enlargement of the left breast. The right breast was compatible with normal development in a 12-year-old girl. The left breast appeared massively swollen and tense (Figure 1). A well defined nonfixed mass measuring about six inches in

diameter was palpated and gave the impression of a solid structure. On attempted transillumination it failed to permit the passage of light. Several superficial veins were present in the overlying skin. There was no evidence of lymphadenopathy. Pelvic examination revealed a virginal introitus, with normal distribution of pubic hair.

Laboratory values were as follows: hemoglobin, 12 gm; hematocrit, 36 percent; white blood cell



Fig. 1

From the Tarboro Clinic, Tarboro, N. C.
Reprint requests to Merrie Meade, Tarboro, N. C. 27886.

count, 4,800 with a normal differential. The urine was normal and a VDRL test was nonreactive.

A chest roentgenogram was interpreted as unremarkable except for the obviously enlarged left breast. Mammography revealed the right breast to be normal. The left breast appeared as a homogeneous increase in density, with no radiologic findings that could rule out malignancy. The radiologist's diagnostic possibilities included (1) diffuse inflammatory carcinoma or sarcoma, or both, and (2) giant adenofibroma.

Hospital course

The patient was taken to the operating room on the fifth day after admission and given general anesthesia. A generous transverse circumlinear incision was made over the mass in the inframammary region of the left breast. The tumor was disclosed as a well encapsulated firm mass which was easily enucleated by finger dissection once the proper plane was found. The frozen section was compatible with a giant fibroadenoma.

Pathology

Gross examination: The spheroidal tumor mass measured 11 cm in diameter and was completely enclosed by a thin, grayish-tan capsule. As the specimen was cut, the gray, firm surface bulged slightly, and no focal changes were present.

Microscopic examination: The tumor mass was enclosed by a thin



Fig. 2

fibrous capsule, and the follicular architecture was obliterated. The fibrous stroma was composed of stellate and spindle-shaped fibroblasts exhibiting no pleomorphism or mitotic figures. The ducts were slightly dilated and were lined by a double layer of epithelial cells (Figure 2).

DISCUSSION

Giant fibroadenoma or benign cystosarcoma phylloides may be bilateral and can start, as in this case, prior to the menarche. The course is marked by rapid, painless enlargement; the mass is firm but usually freely movable. Benign virginial hypertrophy of the breast can also be unilateral or bilateral, but no distinct tumor is palpable, and

there is no thinning or tenseness of the skin over the breast. Neither are there enlarged veins.³⁻⁵

It should be noted that virginial hypertrophy is the least common cause of unilateral breast enlargement. Although carcinoma of the breast is extremely rare in the young female, it does occur. In 1943 Chohnoky reported a case in a 13-year-old girl.⁶

There is some conflict of opinion concerning the pathological differentiation of giant fibroadenoma and benign cystosarcoma phylloides. Some authorities feel that the size and rapid growth of the tumor are sufficient to classify it as cystosarcoma phylloides; others believe that the two lesions are better distinguished on the basis of increased pleomorphism and cellularity of stromal elements. In either case, if the lesion is benign it usually can be easily removed by simple excision, preferably through an inframammary incision; if it is removed early enough, the resultant cosmetic defect can be slight to nonexistent.

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Different forms of medicine, no doubt have their use; but they ought never to be wantonly increased. They are by no means so necessary as is generally imagined. A few grains of powdered rhubarb, jalap, or ipecacuanha, will actually perform all that can be done by the different preparations of these roots, and may also be exhibited in as safe and agreeable a manner. The same observation holds with regard to the Peruvian bark, and many other samples of which the preparations are very numerous.—William Buchan: *Domestic Medicine, or a Treatise on the Prevention and Cure of Diseases by Regimen and Simple Medicines, etc.*, Richard Folwell, 1799, p. 437.

Doctor, What Did You Say?

Hugh A. Matthews, M.D.*

At a seminar on the Western Carolina University campus, a physician spoke before a group of 100 lay people. After an appropriate but spicy introduction, the physician had the industrial workers and businessmen in the palm of his hand. Very soon thereafter, he had lost his audience to obvious boredom or sleep.

The physician presiding at the meeting, although thoroughly enjoying the address, began listing medical terms that the physician lecturer was using. At the end of the address, the terms had been jotted down on a description pad. Fifty of them were changed in a multiple choice examination designed to test only general understanding. Fine distinctions were not required to arrive at correct answers. The choices were reviewed, and in some instances altered, by a medical secretary in the interest of assuring clarity and avoiding trickery.

The multiple choice examination as evolved was given to 41 graduate students in the School of Education and Psychology. All were college graduates and many were in their second year of postgraduate work leading to master's degrees.

These students were on a par with graduate students across the nation in their respective fields. Each ranked at or above the median level of the national Graduate Records Examination (GRE) required for admission to the graduate school. Some had GRE scores higher than the usual requirements for medical school admission.

The examination given to these graduate students was the following:

Hepatic referred to

- A. fever blisters
- B. the liver
- C. need for sympathy

Apneic meant

- A. breathless
- B. an opening
- C. apologetic

Hemiparesis indicated

- A. slight paralysis on one side
- B. half-wittedness
- C. a type of anemia

Hypoxia meant

- A. a false or nonfunctioning organ
- B. an injection of air
- C. a state of decreased oxygen in tissue

Cyanotic implied

- A. a bluish color
- B. a confused state
- C. poisoning with cyanide

I.V. referred to

- A. inverting a blood vessel
- B. a valve to the heart
- C. injecting a substance into a vein

Clonic indicated

- A. rapid contraction and relaxation of muscles
- B. constant spasm of muscle
- C. a procedure to empty the bowels

Fibrillation implied

- A. growth of muscle fibers
- B. very rapid twitching of the heart
- C. compulsion to misrepresent

Tonic indicated

- A. a disturbance in hearing
- B. a normal sense of tone
- C. a continuous contraction of a muscle

Edema referred to

- A. retention of fluid in tissue
- B. a skin disease
- C. a loss of epidermis

Pronate indicated

- A. turning the arms so that the tops of the hands are forward
- B. turning the arms so that the palms of the hands are forward
- C. extending the arms laterally

*Director of Health Affairs, Western Carolina University, Cullowhee, North Carolina 28593.

Stenosis meant

- A. a stretching
- B. a narrowing
- C. a scarring

Viscous referred to

- A. a fluid in the eye
- B. a free flowing liquid
- C. a sticky, slow flowing liquid

Plethoric had reference to

- A. a sluggish person
- B. an excess of body fluids
- C. an emotional attachment

Hypoglycemia indicated

- A. an alteration in blood sugar
- B. a weak glycerin solution
- C. a depressed mood

Uremic related to

- A. an excess of wastes in the blood
- B. a bladder infection
- C. too many red blood cells

Cirrhosis meant

- A. yellow skin
- B. scarring of an organ
- C. a circular skin lesion

Febrile had reference to

- A. old age
- B. abnormal heart rhythm
- C. elevated temperature

Petechiae meant

- A. severe itching
- B. pin point to pin head size hemorrhages
- C. a small opening at the corner of the eye

Syncope referred to

- A. rhythm of the heart
- B. a bout of fainting
- C. combining two or more drugs

Cervical os indicated

- A. a pelvic bone
- B. the collar bone
- C. the opening to the uterus

Epistaxis meant

- A. bleeding from the nose
- B. a top layer of skin
- C. dramatic flow of blood

Arrhythmia indicated

- A. stoppage of the heart
- B. jumping leg muscle
- C. irregular heart beat

Bradycardia implied

- A. a narrow opening
- B. a slow heart action
- C. a scarring of muscle

Pulmonary had reference to

- A. pumping action
- B. the lungs
- C. pulse beat

Cardia pointed to

- A. the opening to the stomach
- B. a valve in the heart
- C. a liver defect

Infarction meant

- A. breaking a medical rule
- B. death of tissue
- C. narrowing of a blood vessel

Cilia referred to

- A. a state of stupidity
- B. hairs in lung tubes
- C. indecisiveness

Cicatrix implied

- A. a scar left by a healed wound
- B. a round lesion
- C. an indefinite time period or year

Dialysis indicated

- A. breaking up scars
- B. passing of a substance through a membrane
- C. dividing one lesion from another

Hirsute made reference to

- A. an excessive growth of hair
- B. an unusually strong muscle system
- C. a primitive vestige

Exogenous meant

- A. originating outside the body
- B. flowing from one organ to another
- C. generating excessive fat

Neurological referred to

- A. good thinking
- B. mental illness
- C. brain and nerves

Comatose implied

- A. injury or disease to the brain
- B. poor oral hygiene
- C. a comic state

Hypertension meant

- A. pulled too tight
- B. nervous or tense
- C. abnormal blood pressure

Glucose referred to

- A. an eye disease
- B. a sugar solution
- C. a thick liquid

Narcosis implied

- A. a group of drugs
- B. a mental illness
- C. a stuporous state

Gavage had reference to

- A. emptying the stomach
- B. feeding by a stomach tube
- C. rubbing the skin

Cerebral referred to

- A. wax in the ear
- B. a primitive medical rite
- C. the brain

Fibroma meant

- A. a cancerous growth
- B. a benign tumor
- C. a normal part of tendons

Metabolic referred to

- A. poisoning by ingesting certain heavy metals
- B. chemical changes whereby nutrition is affected
- C. change in the course of a disease due to a related disease

Endogenous referred to

- A. inherited characteristics
- B. origin of a process within the organism or one of its parts
- C. generation of abnormal hormones

Hysteria indicated

- A. a plant poisonous to human beings
- B. an inappropriate emotional reaction to stress
- C. an infection of the uterus

Hyperglycemia indicated

- A. diabetes
- B. thyroid trouble
- C. excessive breathing

Palpitation referred to

- A. examination by feeling
- B. forceful pulsation of the heart with increased rate
- C. friction on one membrane against another

Barbiturates referred to

- A. psychedelic drugs
- B. sleeping medication
- C. mood-stimulating chemicals

arenteral indicated

- A. influence of parents on offspring
- B. giving medicine in the veins of muscles
- C. overprotectiveness

poplexy meant

- A. a complex of vessels overlying other vessels
- B. an application of a medicated mesh over a wound
- C. a sudden loss of consciousness due to a blockage of an artery

thrombosis indicated

- A. early division of fetal cells
- B. clot formation blocking a blood vessel
- C. stage in developing antibiotics

E.G.

- A. brain waves
- B. excess energy generation
- C. electrical equipment used in gynecology

The highest score was 72, the lowest was 40, and the average was 56. Three students thought that "hepatic" referred to the need for sympathy, and five chose "apneic" to mean apologetic. Ten students thought that "cyanotic" implied poisoning by cyanide and four students thought that "hypoglycemia" indicated a depressed mood. Twenty-eight of the 41 graduate students assumed that "febrile" had reference to abnormal heart rhythm; only one chose elevated temperature as the answer. Eleven thought that

"cervical os" indicated a pelvic bone; eight selected the collarbone, and 22 chose the opening of the uterus. For seven students, "infarction" meant breaking a medical rule, and for two students, "cilia" referred to indecisiveness. Thirty indicated that "hysteria" referred to infection of the uterus. Of the 41 graduate students, none answered that "hysteria" indicated a plant poisonous to human beings, and none thought that "glucose" referred to an eye disease.

Most physicians would find this brief review to be indeed funny. But who deserves to laugh? A reasonable conclusion is that Robert Burns should have thought twice before he prayed for the gift to see ourselves as others see us. Regardless of whether the physician(s) should laugh or not, the graduate students' answers and the physicians' responses appear to merit two suggestions and one conclusion.

The first suggestion is that, in attempting to communicate with patients and groups, physicians might well strive to use the simplest possible terms. Words do not necessarily communicate all that the physician, or any person, intends to communicate. Words are but one possible tool in the communication process. They are but sounds which symbolize objects, concepts, and feelings. If the word symbol has no meaning for the patient, the word indeed symbolizes nothing and be-

comes merely a sound or, at worst, a noise. If no words that have meaning for the patient can be found, the physician must find other tools for communicating. Pictures, models, and demonstrations can serve in some instances and assist in others. There are yet other modalities in communication which can assist in giving meaning to the medical terms which must be used.

A related suggestion is that a physician, preparing to deliver a speech to a lay group, edit and re-edit the paper. He then should have a lay person edit it. The physician who wants to be divorced from the editorial work could ask his or her lay husband or wife to read the paper. If we should choose not to do this, he might do well to submit the speech for critical analysis to his earthy, favorite patient (every physician has one).

The one and final conclusion is that most people, including brilliant graduate students, will never have the interest or the time to develop an effective medical vocabulary. Woe be to the few lay people who do have the time and interest to learn the medical "lingo"! The patient whose chief complaint is, "Doctor, I am apneic," might be better advised to say nothing, just pant. An expectancy more reasonable than having lay folks develop an extensive medical vocabulary is that physicians return to using "plain talk."

Multiplying the ingredients of a medicine, not only renders it more expensive, but also less certain, both in its dose and operation. Nor is this all. The compound, when kept, is apt to spoil, or acquire qualities of a different nature. When a medicine is rendered more safe, efficacious, or agreeable, by the addition of another, they ought, no doubt, to be joined; in all other cases, they are better kept asunder. The combination of medicines embarrasses the physician, and retards the progress of medical knowledge. It is impossible to ascertain the precise effect of any one medicine, as long as it is combined with others, either of a similar or dissimilar nature.—*William Buchan: Domestic Medicine, or a Treatise on the Prevention and Cure of Diseases by Regimen and Simple Medicines, etc., Richard Folwell, 1799, p. 438.*

Editorials

DR. MYRON L. FOX AND DR. THOMAS MORE

It is to be hoped that Oscar Wilde was taken seriously in his observation that Nature imitates Art, for examples of how well he thought out the matter are all around us. Wilde's wisdom came to mind recently, upon reading the published account of Dr. Fox's famous lecture (*J Med Educ* 48: 630-635, 1973). A group of faculty members at the University of Southern California hired a professional actor who "looked distinguished and sounded authoritative; provided him with a sufficiently ambiguous title, Dr. Myron L. Fox, an authority on the application of mathematics to human behavior; dressed him up with a fictitious but impressive curriculum vitae, and presented him to a group of highly trained educators." Dr. Fox's address on "Mathematical Game Theory as Applied to Physician Education" was well received by three separate groups of educators, most of them in psychiatry, psychology and related fields. One of the 55 "victims" even claimed to have read Dr. Fox's publications. The paper itself analyzes the whole affair in considerable detail, and ends with some sour belching about teaching and illusions of learning, going so far as to suggest that hiring actors might be a good way to teach.

Wilde comes into all this when one considers how incisively and amusingly Walker Percy covered similar ground in his 1971 masterpiece *Love in the Ruins* (New York: Farrar, Straus, and Giroux, Inc.). Surely one of the best novels of recent years, Percy's book provides many insights and vignettes dealing with medical matters, which is understandable since he is a physician (and a southerner, which bears importantly on many of his other views). One of the memorable scenes of the novel is a parody of a CPC

in which Dr. Percy clearly shows, these exercises are the theatrical events they are (where still held, and the participants as actors and audience, with the interactions one might expect and a whole lot only Percy could think of. In the novel the students get the more vigorous putdown, as opposed to Fox teachers: "Students are, if the truth be known, a bad lot. En masse, they're fickle as a mob, manipulated by any professor who'll stoop to it. They have, moreover, an infinite capacity for repeating dull truths and old lies with all the insistence of self-discovery. Nothing is drearier than the ideology of students, left or right."

Considering that the Art involved in this editorial comes from a novel, and the Nature from Southern California, can one safely write off lecturers and the students as a bad lot and leave them with the painful Pilatean cry, "Kill each other, damn you"? Hardly. One could easily argue that the particular audience seduced by Dr. Fox were more homogeneous and more susceptible than the average run of medical students (or people walking past the medical school on routine business). While there are exceptions, medical students of the ordinary sort in most parts of the country have been second to none in their eagerness to detect a phony, at times immolating a few innocents in their zeal. Most medical school teachers are concerned with getting accurate, up-to-date information across to the students rather than conforming to television-actor models about whom most are ignorant. Surely the alternative to having a phony on the students (worthy only of Dr. Percy's American Christian Proctological Society) is having an energetic, informed and enthusiastic teacher—not someone so disorganized, dull and generally unattractive that there would be no danger of confusing him with a con man.

Emergency Medical Services



THE SCENE OF AN ACCIDENT

George T. Wolff, M.D., Member
Commission on Health Care Services

The American Academy of Family Physicians

Because of an increasing number of accidents and infrequency with which trained personnel are at scene of an accident, there is an increasing need training the public in first aid and for having delines to reinforce this knowledge when an acci- it occurs. It is suggested that these guidelines be ighed to the glove compartment door.

The major points should include FIRST, be calm, carefully and purposefully, and seek help. A uni- sal emergency telephone number would be help- SECOND, insure an adequate airway. THIRD, indicated, perform closed chest heart massage.

FOURTH, control bleeding if possible. FIFTH, mobilize areas of which there is suspicion of fracture, being especially cognizant of spinal fractures. SIXTH, keep the patient warm and covered. This instruction should be carried out by already-function- ing organizations and perhaps should be required as part of our education program. Trained emergency technicians, nurses, and doctors are not enough to do this job.

—Abstracted by GEORGE JOHNSON, JR., M.D.

From "Emergency Medicine Today," Commission on Emergency Medical Services, Volume 3, No. 2, February 1974. Original article may be obtained from American Medical Association, 535 North Dearborn Street, Chicago, Illinois 60610.

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Correspondence

Louise Fant MacMillan

To the Editor:

I write this letter hoping to express my great sorrow in the passing of Louise MacMillan. She served so long as the assistant editor of the NORTH CAROLINA MEDICAL JOURNAL and did it superbly.

We all knew her as a sensitive, extremely intelligent, bright person with a fine sense of humor but a fine judgment and unafraid to criticize when that time came. In spite of her handicap, being a paraplegic for her many years, she scarcely recognized any disability. I remember once in discussing that we were to have a meeting of the paraplegics at some place where there was a hindrance at the doorway, Louise laughed this off with a statement, "Well, any able-bodied paraplegic ought to be able to get over that." She never thought of herself as disabled and certainly contributed a great deal to the lives of many people. She will be missed by all of us and particularly by those around the Bowman Gray School of Medicine Baptist Hospital Medical Center.

EBEN ALEXANDER, JR., M.D.
Professor of Neurosurgery
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Personal Testimonies on Medical-Ethical Issues

To the Editor:

I am currently editing a book on the personal testimonies of Christian physicians and how they view the current medical-ethical issues of today, i.e., abortion, euthanasia, organ transplants, when a person is officially dead, sterilization, psychosurgery, semen donors, ovum donors, host mothers, reversal of aging, artificial organs, genetic counseling, etc. I would be interested in hearing from any Christian physician who would be interested in contributing to such a book, or who would be able to suggest a Christian physician to write for this book. Please contact me at the following address:

CLAUDE A. FRAZIER, M.D.
4-C Doctor's Park
Asheville, N. C. 28801

Committees and Organizations

INSURANCE INDUSTRY COMMITTEE

Charlotte, Jan. 16, 1974

Following discussion of the action taken by the Committee on Sept. 26, 1973, with respect to the support of this Committee for the continuance of coordination of benefits clauses in all insurance contracts in effect in North Carolina, it was the consensus that the wording should read as follows:

With respect to all employer-employee insurance plans in effect in North Carolina, containing a coordination of benefits provision, it is the opinion of this Committee that such provisions should be maintained in effect in order to reduce duplication of benefit payments with the consequent effect of slowing the rise in the cost of medical care.—BERNARD WANSKER, M.D., *Chairman*

Bulletin Board

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Moskalik, Robert Stephen (Student), 429 Northside Dr.,
Chapel Hill 27514
Pena, Horacio, MD (GP), P. O. Box 308, Clarkton, NC
Phillips, Bruce Alton, Jr., MD (IM), P. O. Box 86,
Elizabethtown, NC
Rogers, Noel Bruce, MD (ORS), 200 Doctors Dr., Jackson-
ville 28540
Sessoms, Stuart McGuire, MD (IM), Duke Hospital,
Durham 27710
Shrivastav, Rajendra, MD (Intern-Resident), New Hanover
Hosp., Wilmington 28401
Staab, Edward Vincent, MD (R) 605 Churchill Dr., Chapel
Hill 27514
Stabler, Carey Vastine, MD (IM) 3041 St. Claire Rd.,
Winston-Salem 27106
Tejano, Felipe Mazon, MD (U), 2200 Sparre Dr., Kinston
28501
Tucker, Paul Chambliss, Jr., MD (IM), 1350 S. Kings
Dr., Charlotte 28207
Vaidyanathan, Shankar Kuther, MD (GS), 1540 Garden
Terr. Apt. 305, Charlotte 28201
Wallace, Kelley, MD (PS), 1705 W. 6th St., Greenville
27834
Wiecher, Frederick Jos., MD (Intern-Resident), 6709 Ronda
Ave., Charlotte 28207

WHAT? WHEN? WHERE?

In Continuing Education

May 1974

("Place" and "sponsor" are listed only where these differ
from the place and group or institution listed under "for
information.")

In North Carolina

May 15

Ethel Nash Day Program
Place: Clinic Auditorium; 1:00 to 5:30 p.m.
Sponsor: Department of Obstetrics and Gynecology
For Information: Miss Ann Francis, Administrative Assis-
tant, Office of Continuing Education, UNC School of
Medicine, Chapel Hill 27514.

May 16-18

Basic Mechanisms in Hypertension, previously scheduled for
this date by the Bowman Gray School of Medicine, has
been cancelled.

May 18-22

120th Annual Session of the North Carolina Medical So-
ciety; General Session on Scientific Subjects and Specialty
Section Meetings
Place: Pinehurst Hotel and Country Club
For Information: Mr. William N. Hilliard, Executive Direc-
tor, P. O. Box 27167, Raleigh 27611

May 20-21 and May 23-24

Nursing Evaluation and Documentation
Place: Royal Villa, Raleigh, May 20-21; Downtowner East, Charlotte, May 23-24
Intended Participants: Hospital nursing personnel
Fee: \$75
For Information: Mr. Jay Camp, North Carolina Hospital Association, P. O. Box 10937, Raleigh 27605

May 28-31

Fourth postgraduate course in Head & Neck Anatomy
Sponsors: Department of Anatomy, School of Medicine, in cooperation with the Division of Continuing Education, East Carolina University
Eligibility: Open to holders of any of following degrees: M.D., D.D.S., D.M.D., Ph.D.
Fee: \$125, students in residency programs \$75
Credit: Approved for 28 hrs. AAFP elective hours; CE units also given by Division of Continuing Education, ECU
For Information: Head & Neck Anatomy Course, ECU Division of Continuing Education, P. O. Box 2727, Greenville 27834

May 29-30

Hypertension: Critical Problems—25th Annual Meeting and Scientific Sessions, North Carolina Heart Association
Place: Hyatt House and Convention Center, Winston-Salem
Designed especially for nurses and physicians
For Information: North Carolina Heart Association, 1 Heart Circle, Chapel Hill 27514

June 12-15

Neurology for Practicing Physicians, originally scheduled by the Bowman Gray School of Medicine for this date, has been cancelled.

June 13-16

Seaboard Medical Association Annual Meeting
Place: Holiday Inn, Kill Devils Hill
For Information: Mrs. Annette Boutwell, P. O. Box 10387, Raleigh 27605

June 20-22

Mountain Top Assembly
Place: Waynesville Country Club, Waynesville
For Information: R. Stuart Roberson, M.D., P. O. Box 307, Hazlewood 28738

July 8-13

16th Annual Duke Medical Post Graduate Course
Place: Atlantis Lodge, Atlantic Beach, North Carolina
Program: designed primarily for the generalist, but with sufficient variation to appeal to the interest of the internist and the pediatrician. Conferences and lectures will be given in the morning; afternoons and evenings will be left free for recreational activities.
Fee: \$85, payable in advance. Course limited to 75 participants.
Credit: A certificate of attendance will be given. Program is acceptable for 30 accredited hours by AAFP.
For Information: W. M. Nicholson, M.D., P. O. Box 3088, Duke University Medical Center, Durham 27710.

July 29-August 2

2nd Annual Beach Workshop. Selected Topics in General Internal Medicine
Sponsors: Bowman Gray, Duke and UNC Schools of Medicine, in conjunction with the Medical University of South Carolina
Place: St. Johns Inn, Myrtle Beach, South Carolina
Fee: \$100
For Information: Emery C. Miller, M.D., Associate Dean for Continuing Education, Bowman Gray School of Medicine, Winston-Salem 27103

September 20-21

1974 Walter L. Thomas Symposium on Gynecologic Malignancy and Surgery
Program: The two-day symposium will be clinically oriented with the main emphasis on "Ovarian Cancer" and "Dif-

NEW! Patient Therapy Packs

Because many patients tend to stop treatment prematurely, the full course of b.i.d. therapy is now specially packaged to encourage patients to complete the full course of therapy.

CANDEPTIN Vaginal Ointment Therapy Pack—two 75 gm. tubes

CANDEPTIN Vagettes Therapy Pack—28 vaginal capsules

CANDEPTIN Vaginal Tablet Therapy Pack—28 vaginal tablets

Brief Summary

Description: CANDEPTIN (Candidin) Vaginal Ointment contains a dispersion of Candidin powder equivalent to 0.6 mg. per gm. or 0.06% Candidin activity in U.S.P. petrolatum. 3 mg. of Candidin is contained in 5 gm. of ointment or one applicatorful. CANDEPTIN Vaginal Tablets contain Candidin powder equivalent to 3 mg. (0.3%) Candidin activity dispersed in starch, lactose and magnesium stearate.

CANDEPTIN VAGETTES Vaginal Capsules contain 3 mg. of Candidin activity dispersed in 5 gm. U.S.P. petrolatum.

Action: CANDEPTIN Vaginal Ointment, Vaginal Tablets, and VAGETTES Vaginal Capsules possess anti-monomial activity.

Indications: Vaginitis due to *Candida albicans* and other *Candida* species

Contraindications: Contraindicated for patients known to be sensitive to any of its components. During pregnancy manual Tablet or VAGETTES Capsule insertion may be preferred since the use of the ointment applicator or tablet inserter may be contraindicated.

Caution: During treatment it is recommended that the patient refrain from sexual intercourse or the husband wear a condom to avoid re-infection.

Adverse Reaction: Clinical reports of sensitization or temporary irritation with CANDEPTIN Vaginal Ointment, Vaginal Tablets or VAGETTES Vaginal Capsules have been extremely rare.

Dosage: One vaginal applicatorful of CANDEPTIN Ointment or one Vaginal Tablet or one VAGETTES Vaginal Capsule is inserted high in the vagina twice a day, in the morning and at bedtime, for 14 days. Treatment may be repeated if symptoms persist or reappear.

Available Dosage Forms: CANDEPTIN Vaginal Ointment is supplied in a Patient Therapy Pack, containing two 75 gm. tubes with two applicators for the full course of treatment. CANDEPTIN Vaginal Tablets are packaged in boxes of 28, in foil with inserter—enough for a full course of treatment. CANDEPTIN Vagettes Vaginal Capsules are packaged in a Patient Therapy Pack, containing 28 CANDEPTIN Vagettes Vaginal Capsules (2 boxes of 14), for the full course of treatment. Store under refrigeration to insure full potency.

Federal law prohibits dispensing without prescription.

References:

1. Melges, F. J.: *Obstet. Gynecol.* 24:921, Dec. 1964
2. Cameron, P. E.: *Practitioner* 202:695, May 1969
3. Olsen, J. R.: *Journal-Lancet* 85:287, July 1965
4. Giorlando, S. W.: *OB/GYN Digest* 13:32, Sept. 1971
5. Decker, A.: Case Reports on file, Medical Department, Julius Schmid
6. Friedel, H. J.: *Md. State Med. J.* 15:36, Feb. 1966
7. Roberts, C. L. and Sullivan, J. J.: *Calif. Med.* 103:109, Aug. 1965
8. Giorlando, S. W., Torres, J. F. and Muscillo, G.: *Am. J. Obstet. Gynecol.* 90:370, Oct. 1, 1964
9. Abruzzi, W. A.: *Western Med.* 5:62, Feb. 1964

Innovators in candidin therapy

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VOL. 35, No. 5

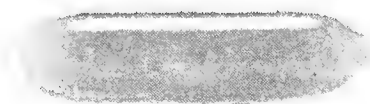
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The highly effective
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- *the only candicidin available in three dosage forms* for complete therapeutic flexibility—even for adolescent and gravid patients.
- *Symptomatic relief* in many patients as early as 48-72 hours¹⁻³; usually cures in a single 14-day course of therapy.
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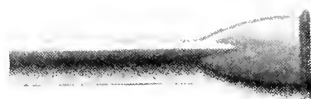
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ficult Office Gynecology." Invited guest speakers include Dr. J. Donald Woodruff, Baltimore, Maryland; Dr. Herbert Buchsbaum, Iowa City, Iowa; and Dr. J. Taylor Wharton, Houston, Texas.
Credit: AAFP credit applied for.
For Information: W. T. Creasman, M.D., Director of Gynecologic Oncology, P. O. Box 2079, Duke University Medical Center, Durham 27710

October 20-22

Annual Joint Meeting of the North Carolina-South Carolina Societies of Ophthalmology and Otolaryngology
Place: Asheville Hilton Inn, Asheville, N. C.
Sponsor: The North Carolina Society of Ophthalmology and Otolaryngology
For Information: Banks Anderson, Jr., M.D., Secretary-Treasurer, P.O. Box 3802, Duke University Eye Center, Durham 27710

October 28-November 1

Radiology Postgraduate Course
Place: Southampton Princess Hotel, Southampton, Bermuda
Program Chairman: Richard G. Lester, M.D., Professor and Chairman of Radiology, Duke University Medical Center.
Guest speakers will include: Robert G. Fraser, M.D., Professor and Chairman of Radiology, McGill University Medical School, Montreal, Canada; John A. Evans, M.D., Professor and Chairman of Radiology, Cornell University Medical College; William B. Seaman, M.D., Professor and Chairman of Radiology, Columbia University College of Physicians and Surgeons, New York, N. Y.; Harold G. Jacobson, M.D., Professor and Chairman of Radiology, Albert Einstein College of Medicine (MHMC), Bronx, New York; and David H. Baker, M.D., Director of Radiology, Babies Hospital, Professor of Radiology, Columbia University College of Physicians and Surgeons, New York, N. Y. Subject matter will cover Pediatric and Adult Radiology of the Chest, Genitourinary Tract, Gastrointestinal Tract and Musculoskeletal System.
Fee: \$200
Credit: Twenty-three hours AMA "Category One" accreditation
For Information: Robert McLelland, M.D., Department of Radiology, Box 3808, Duke University Medical Center, Durham 27710.

Loan Materials Available

A packet of materials to help you Train Your Own Assistant is available to members on a loan basis from Medical Society headquarters. It includes a color TV tape cassette, practice forms for planning and evaluation, and TV tape evaluation report forms. For more information write Mr. Gene Sauls, North Carolina Medical Society, P. O. Box 27167, Raleigh 27611.

IN CONTIGUOUS STATES

September 30 & October 1

Tennessee Valley Medical Assembly annual meeting
For Information: Thomas L. Buttram, M.D., Chairman, Tennessee Valley Medical Assembly, Whitehall Medical Center, 960 E. Third Street, Chattanooga, Tennessee 37403

October 5-8

Southern Psychiatric Association annual meeting
Place: The Homestead, Hot Springs, Virginia
For Information: Mrs. Annette Boutwell, P.O. Box 10387, Raleigh 27605

Items submitted for listings should be sent to: WHAT? WHEN? WHERE?, P. O. Box 8248, Durham, N. C. 27704, by the 10th of the month prior to the month in which they are to appear.

News Notes from the—

UNIVERSITY OF NORTH CAROLINA DIVISION OF HEALTH AFFAIRS

Paul Roger Van Ostenberg was recently appointed assistant professor in the Department of Dental Ecology, UNC School of Dentistry. He received his B.A. at the University of South Florida and his D.D.S. at the Medical College of Virginia. He came to UNC from the University of Virginia Hospital and Medical School where he was director of dental education, Child and Youth Center, and an assistant professor.

* * *

Dr. Eugene Wright has been elected president of the Research Triangle branch of the American Association for Laboratory Animal Science. He is a clinical veterinarian for the UNC Medical School's Division of Laboratory Animal Medicine. Dr. Wright joined the UNC faculty in 1972 after a year on the Texas A & M University faculty where he received his D.V.M. and M.S. degrees.

* * *

Frederic C. Shorter, professor, part-time, Department of Biostatistics, resigned Dec. 31 to accept a position with the Population Council in New York City.

* * *

Joe T. Wall, Department of Operative Dentistry, UNC School of Dentistry, has been promoted to associate professor.

* * *

Promotions to assistant professor in the UNC School of Medicine include: Jonathan R. Davidson, psychiatry; Hanson Y. Chuang, pathology and biochemistry and nutrition; Barry R. Howes, physical therapy; James A. Merchant, medicine; and Wayne Nopanitaya, pathology.

* * *

Herbert A. Cooper, assistant professor, Departments of Pathology and Pediatrics, currently is completing a residency and postdoctoral traineeship at the UNC School of Medicine. He received his B.S. and M.D. degrees at the University of Kansas.

* * *

J. W. Edgerton, professor, Department of Psychiatry, is on leave for the entire 1974 year to assume duties as South Central Regional Mental Health director, Division of Mental Health Services, N. C. Department of Human Resources.

James J. Murphy, assistant professor, Department of Radiology, resigned March 31 to enter private practice.

James L. Howard, assistant professor, Department of Psychiatry, resigned April 30 to accept a position with Burroughs-Wellcome.

Single-car crashes killed 1,247 drivers in North Carolina from 1970 through 1973. Of these, 851 (two-thirds) were either under the influence of alcohol or had been drinking.

Dr. Arthur J. McBay, chief toxicologist for the office of the chief medical examiner, announced these findings upon completion of a four-year study conducted at UNC-Chapel Hill.

* * *

If present trends continue, North Carolina will spend \$500 million on rehabilitating alcoholics between now and the end of the century, according to Dr. John A. Ewing, director of the Center of Alcohol Studies at UNC-Chapel Hill.

Unless something is done to prevent the development of new cases, there will be more North Carolinians with alcoholism in the year 2000 than the 10,000 cases we presently have, Ewing said.

He made the remarks before the newly established North Carolina Alcoholism Research Authority of which he has become the first executive secretary. Ewing's message also is being delivered to all members of the General Assembly now in session.

* * *

Three UNC School of Medicine faculty members are studying acupuncture and medication to determine which lowers high blood pressure more effectively. The study began this year when Dr. James Woods, professor of medicine, and R. A. Mueller, a Ph.D. in Pharmacology, set up a study to examine the effects of the two most commonly prescribed drugs given to patients with "essential" hypertension. Essential hypertension means there is no known organic cause.

Dr. Kenneth Sugioka, chairman of the Department of Anesthesiology, decided to investigate claims that acupuncture is highly effective in the treatment of hypertension. "These claims have to be given credibility or squashed," he said.

The three researchers have received a \$36,000 grant from the National Heart and Lung Institute for the combined study, only the second grant given in the U. S. for the study of acupuncture.

* * *

A research project which ultimately may reduce the incidence and severity of byssinosis (biss-eh-nosis) among cotton textile workers will be conducted by the School of Medicine at UNC-Chapel Hill and the School of Textiles at North Carolina State University.

Often called "Monday fever," byssinosis is the only respiratory condition of cotton workers in which chest tightness, coughing, and wheezing have their onset on the first day of the working week. Symptoms usually disappear an hour or so after leaving work, but they may reappear on subsequent workdays after continued exposure. It is believed that irreversible obstructive airway disease eventually appears.

The research project is being funded by a grant

from Cotton Incorporated. Dr. Mario C. Battigelli, associate professor of medicine and a recognized authority on byssinosis, will direct research at UNC-Chapel Hill. Dr. Richard Gilbert, professor of textile chemistry at NC State University, will direct the research at the School of Textiles. Dr. Janet Fischer, associate director of the microbiology laboratory at N. C. Memorial Hospital in Chapel Hill, will conduct bacteriological studies of the dust samples and monitor use of the dust to prevent bacterial and fungal contamination.

* * *

Dr. Berton Kaplan, an avid tennis player and a member of the UNC School of Public Health faculty at Chapel Hill, thinks there is a relationship between health and the way people play outdoor games. With tongue in cheek, he describes his ideas in "Speculations on the Health Consequences of Tennis Playing Styles," part of a forthcoming book entitled *Tennis Psychology* edited by Dr. Claude Frazier. Dr. Kaplan is a professor of epidemiology in the UNC School of Public Health.

* * *

The professional library of the late Dr. Mindel Cherniack Sheps, former professor in the UNC School of Public Health's Department of Biostatistics, has been donated to the University's Health Sciences Library.

Myrl Ebert, chief librarian, said the gift was made through the generosity of the late Dr. Sheps' husband, Dr. Cecil G. Sheps, UNC vice chancellor for health sciences in Chapel Hill.

The collection, given in the late Dr. Sheps' memory, will be known as the Mindel C. Sheps Collection in Biostatistics and Mathematical Demography. It contains 400 volumes and reflects Dr. Sheps' interests during her distinguished career.

* * *

The UNC School of Public Health began its newest off-campus master's degree program in Asheville during February. Dr. Bernard G. Greenberg, dean of the school, said the program was designed in cooperation with the Area Health Education Center program, the School of Public Health, and UNC at Asheville.

Like the School of Public Health's first such program in Raleigh, the new one will focus on health administration. It is designed to improve health and human services administration.

Ms. Lydia Holley of the UNC School of Public Health will direct the Asheville program.

* * *

The UNC School of Dentistry has received a \$128,000 general research support grant from the National Institutes of Health in Washington, D. C.

Announcement of the grant was made by Dr. James W. Bawden, dean of the School at Chapel Hill. This year's grant is a major increase over the \$69,000 received last year, Bawden said.

The one-year grant will be used to fund support fa-

cilities within the Dental Research Center as well as oral health related research and research training, according to Dr. Gary R. Smiley, principal investigator and acting associate dean for research.

News Notes from the—

DUKE UNIVERSITY MEDICAL CENTER

Dr. James B. Sidbury, Jr., says Americans have been taught to believe that a fat, round baby is a healthy baby and that a healthy child must eat a set amount of food every day. He believes that this early training leads to a pattern of overeating which is the main factor in childhood obesity. Sidbury says that 80 percent of fat children end up as fat adults.

Sidbury, chief of pediatric metabolism and director of clinical research at Duke, began three years ago developing a diet program for treating obese children.

The diet program begins with either a four-day stay in the hospital, or a month-long stay for the grossly obese who need medical attention while dieting. Those who must stay for a month are supported by research funds. The most important part of the hospital stay is education in diet and dieting.

* * *

The Pharmaceutical Manufacturers Association Foundation has awarded a two-year research starter grant to Dr. Vincent W. Dennis. The \$10,000 grant will help establish a laboratory in Duke's Division of Nephrology to study how substances are transported across renal tubular cell membranes.

* * *

Two officials of the medical center are among the ten winners of this year's Awards for Distinguished Achievement presented by *Modern Magazine*. The two are Dr. William G. Anlyan, vice president for health affairs and professor of surgery, and Dr. James B. Wyngaarden, professor and chairman of the Department of Medicine.

* * *

Four appointments at the medical center have been announced by University Provost Frederic N. Cleaveland.

Appointed to assistant professorships are Dr. James E. Hall, physiology; Dr. Edward W. Holmes, medicine; Dr. Robert David Nebes, medical psychology; and Dr. John L. Sullivan, psychiatry.

* * *

Twelve Duke researchers are among 36 throughout the state who have been approved for grants-in-aid this year by the N. C. Heart Association (NCHA).

In addition to the \$88,738 in grants-in-aid, the association also supports senior research investigators at the three medical schools, making current NCHA support to state researchers \$124,738. In addition,

Rondomycin (methacycline HCl)

CONTRAINDICATIONS

Hypersensitivity to any of the tetracyclines. **WARNINGS** Tetracycline usage during tooth development (last half of pregnancy to 18 years) may cause permanent tooth discoloration (yellow-gray-brown), which is not common during long-term use but has occurred after repeated short-term courses. Enamel hypoplasia has also been reported. **Tetracyclines should not be used in this group unless other drugs are not likely to be effective or are contraindicated.**

Usage in pregnancy. (See above **WARNINGS** about use during tooth development.) Animal studies indicate that tetracyclines cross the placenta and can be toxic to the developing fetus (often related to retardation of skeletal development). Embryotoxicity has also been noted in animals treated early in pregnancy.

Usage in newborns, infants, and children. (See above **WARNINGS** about use during tooth development.)

All tetracyclines form a stable calcium complex in any bone-forming tissue. A decrease in fetal bone growth rate observed in premature given oral tetracycline 25 mg/kg every 6 hours was reversible when drug was discontinued.

Tetracyclines are present in milk of lactating women taking tetracyclines.

To avoid excess systemic accumulation and liver toxicity in patients with impaired renal function, reduce usual total dosage and if therapy is prolonged, consider serum level determinations of drug. The anti-anabolic action of tetracyclines may increase BUN. When not a problem in normal renal function, in patients with significantly impaired function, higher tetracycline serum levels may lead to azotemia, hyperphosphatemia, and acidosis.

Photosensitivity manifested by exaggerated sunburn reaction has occurred with tetracyclines. Patients apt to be exposed to direct sunlight or ultraviolet light should be advised, and treatment should be discontinued at first evidence of skin erythema.

PRECAUTIONS If superinfection occurs due to overgrowth of nonsusceptible organisms including fungi, discontinue antibiotic and start appropriate therapy.

In venereal disease, when coexistent syphilis is suspected, perform darkfield examination before therapy, and serologically test for syphilis monthly for at least four months.

Tetracyclines have been shown to depress plasma prothrombin activity; patients on anticoagulant therapy may require downward adjustment of their anticoagulant dosage.

In long-term therapy, perform periodic organ system evaluations (including blood, renal, hepatic).

Treat all Group A beta-hemolytic streptococcal infections for at least 10 days.

Since bacteriostatic drugs may interfere with the bactericidal action of penicillin, avoid giving tetracycline with penicillin.

ADVERSE REACTIONS Gastrointestinal (oral and parenteral forms): anorexia, nausea, vomiting, diarrhea, glossitis, dysphagia, enterocolitis, inflammatory lesions (with local overgrowth) in the anogenital region.

Skin: maculopapular and erythematous rashes, exfoliative dermatitis (uncommon). Photosensitivity is discussed above. (See **WARNINGS**.)

Renal toxicity rise in BUN, apparently dose related. (See **WARNINGS**.) **Hypersensitivity** urticaria, angioneurotic edema, anaphylaxis, anaphylactoid purpura, pericarditis, exacerbation of systemic lupus erythematosus.

Bulging fontanels reported in young infants after full therapeutic dosage have disappeared rapidly when drug was discontinued.

Blood hemolytic anemia, thrombocytopenia, neutropenia, eosinophilia.

Over prolonged periods, tetracyclines have been reported to produce brown-black discoloration of thyroid glands, no abnormalities of thyroid function studies known to occur.

USUAL DOSAGE Adults—600 mg daily, divided into two or four equally spaced doses. More severe infections: an initial dose of 300 mg followed by 150 mg every six hours; 300 mg every 12 hours. Gonorrhea. In uncomplicated gonorrhea, when penicillin is contraindicated, Rondomycin (methacycline HCl) may be used for treating both males and females in the following clinical dosage schedule: 900 mg initially, followed by 300 mg q 12 h for a total of 5.4 grams.

For treatment of syphilis, when penicillin is contraindicated, a total of 18 to 24 grams Rondomycin (methacycline HCl) in equally divided doses over a period of 10-15 days should be given. Close follow-up, including laboratory tests, is recommended.

Eaton Agent pneumonia: 900 mg daily for six days.

Children—3 to 6 mg/lb. day divided into two to four equally spaced doses.

Therapy should be continued for at least 24-48 hours after symptoms and fever have subsided.

Concomitant therapy Antacids containing aluminum, calcium or magnesium impair absorption and are contraindicated. Food and some dairy products also interfere. Give drug one hour before or two hours after meals. Pediatric oral dosage forms should not be given with milk formulas and should be given at least one hour prior to feeding.

In patients with renal impairment (see **WARNINGS**), total dosage should be decreased by reducing recommended individual doses or by extending time intervals between doses.

In streptococcal infections, a therapeutic dose should be given for at least 10 days. **SUPPLIED** Rondomycin (methacycline HCl) 150 mg and 300 mg capsules, syrup containing 75 mg/5 cc methacycline HCl.

Before prescribing, consult package circular or latest PDR information.

Rev. 6/78



WALLACE PHARMACEUTICALS
CRANBURY, NEW JERSEY 08512

...a package insert in many instances. This would constitute a substantial saving for the manufacturer.

By a complete compendium, I do not mean a volume of prohibitive size. You don't need a book describing 25,000 products with an enormous amount of repetition. Rather, drugs should be arranged by class. Mutually applicable information would be provided, along with brief discussions pinpointing differences in specific drugs of that class. Listings would be cross-indexed in a useful way.

Other Available Documents as Sources of Information

Existing references such as PDR and the AMA Drug Evaluation are obviously useful but they are incomplete. Either they are not cross-referenced by generic name and do not group drugs with similar characteristics, or they do not include all the available and legally marketed drugs. And some of those omitted may be very useful.

...ould in no way imply control over the practitioner's prerogatives.

Why Another Compendium?

A practicable, single-volume compendium cannot, nor is it necessary to, include all drugs on the market today. From my practice of internal medicine for some 30 years, my experience as a consultant, and as a faculty member of four or five medical schools, I would estimate that a doctor uses only 30 to 35 drugs regularly. The 1972 Physicians' Desk Reference, incidentally, contained about 2,000 entries.

As to whether there should be a federal compendium, in my opinion, as stated earlier, the answer is yes—there should *not* be one. The proposal assumes that existing compendia are inadequate. We're not sure of that at all. Whatever its imperfections, the present drug information system in the U.S. is often, multifaceted, pluralistic and expensive. Good compendia exist, as well as other ample sources on drug therapy, ranging from journal literature through AMA Drug Evaluation to company materials. Not all physicians may use such sources as often or as well as they should, but that is the fault of the doctor, not of the sources.

In any event, rather than pro-

On the other hand, drugs made by more than one supplier, tetracycline for example, may be fully described a dozen times in the same book.

While perhaps PDR could be rearranged and cross-indexed with generics included, and while the AMA Drug Evaluation might also be modified and expanded, I am not sure that the end result would have all the attributes required for a useful compendium. At the same time, you would run the risk of amassing a voluminous and unwieldy tome.

Should Editorial Comments Accompany the Listings?

Subjective judgments, in my opinion, have no place in a compendium. However, if there is substantial evidence based on a sound body of science concerning relative efficacy of several drugs, certainly that information should be included. The committee of experts compiling and editing a particular section would also have to assess

duce another book, it makes much more sense to work on improving existing compendia, and perhaps they could, as knowledge advances, include more accumulated clinical data and experience, and more information on drug interactions and adverse reactions.

Implications of a Federal Compendium

Take a hard look at the implications of a federal compendium. It would have the force of law, virtually dictating what drugs to use and how to use them. In effect, it would be a regulatory document with legal or quasi-legal status, posing medical/legal problems similar to those the doctor may now encounter if and when he departs from the provisions of the package insert. A compendium under federal aegis would tend to restrict decisions on drug therapy to one orthodox level—a most dangerous trend for medicine.

New Compendium—A Medical Option

I detect no ground swell of initiative or support whatsoever for a federal compendium—or, for that matter, for a new compendium of any type. A 1969 PMA survey conducted by Opinion Research Corporation found that only 15 per

and indicate instances where a meaningful difference between drugs is pertinent.

Sponsorship, Compilation and Editing

Producing a book like this would undoubtedly be difficult and demanding. It would obviously take a great deal of talent and expertise, and would require a varied and experienced group, ranging from writers and editors to highly skilled clinicians and pharmacologists. Style, format and clarity of language would play an important part in determining the usefulness of the book. And it should be updated periodically and completely revised annually.

I have no opinion whether the government or the private sector should sponsor and/or finance the compendium. What is most important is that the compendium be an authoritative, objective and useful source of information for the doctor to have at hand as a ready reference.

cent of those physicians interviewed felt a new compendium was needed. And a large majority did not favor the involvement of the federal government if one were to be created, preferring instead a nongovernmental consortium.

Even if we come to a time when the medical profession itself opts for a new kind of compendium, it should be handled and financed, ideally, outside both government and industry. Final review and editorial authority could be delegated, say, to specialty bodies and medical societies—but above all, *not* the government.

Surely the health care system in the United States has far more vital matters to consider than the extensive cost and effort that would have to go into the preparation and maintenance of a new, monolithic compendium, and especially one bearing the imprimatur of the federal government.

Opinion & Dialogue

What is your opinion, doctor? We would welcome your comments.

The Pharmaceutical Manufacturers Association
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the American Heart Association currently is granting \$305,312 for research to North Carolina scientists.

The Duke researchers receiving grants-in-aid this year are: Drs. Robert M. Bell, Lee E. Limbird, Lewis Thomas Williams, Walter N. Duran, Harold C. Strauss, Harry Clark Beall, Page A. W. Anderson, Ronald Stephen Aronson, Charles R. Horres, Walter G. Wolfe, Robert W. Anderson, and William C. Devries.

* * *

Duke and Burroughs-Wellcome Co. will launch a cooperative program in clinical pharmacology designed to enhance the development and testing of new drugs.

Representatives of the medical center and the pharmaceutical company have signed a three-year, renewable agreement setting up a Wellcome Unit in the Division of Clinical Pharmacology at Duke.

The unit will be staffed by a group leader and members who are full-time faculty members of Duke. They will have joint appointments in the Pharmacology Division and in one of the medical center's clinical departments. A grant from Burroughs-Wellcome to the university will pay for salaries and supplies for the unit.

News Notes from the—

BOWMAN GRAY SCHOOL OF MEDICINE WAKE FOREST UNIVERSITY

The Bowman Gray School of Medicine has received a \$53,199 grant from the National Fund for Medical Education to develop a new audiovisual self-instructional course in radiographic anatomy.

Dr. Joseph E. Whitley, professor of radiology, heads the program which will be a cooperative effort between the departments of anatomy and radiology of Bowman Gray and the State University of New York, Downstate Medical Center, in Brooklyn.

If the program proves successful it will be made available to other medical schools.

The two-year grant, effective July 1, is intended to help provide more efficient teaching methods to allow the future physician to learn what he must know to give patients the best possible care.

While the new course will be developed primarily for freshman anatomy students, it may also be used by advanced medical students, interns, and residents who would like to review the material.

Working with Dr. Whitley will be Dr. Lucy Frank Squire, professor of radiology at the State University of New York, Downstate Medical Center, and Dr. J. Meschan, professor and chairman of the Department of Radiology at Bowman Gray.

They plan to have a prototype of the program

ready this fall for use in teaching freshman anatomy students at both institutions. The final prototype is scheduled to be completed next year.

The project will include the production of 12 audiovisual programs with a running time of about 30 minutes per student per session. Each student will be pre-tested before beginning the course.

The schedule calls for students at Downstate Medical Center to receive the new course. Bowman Gray students will be given the new course in addition to a formal 12-hour course in radiographic anatomy.

These students will be tested upon completion of the course and test scores will be compared to scores from the same test which will be given to a former class at Bowman Gray which received only the 12-hour course in radiographic anatomy and a former class at the Downstate Medical Center which received no course in radiographic anatomy.

* * *

Dr. Frederick Kremkau, research instructor in medicine and a research associate in neurology, has been appointed to the Bioacoustics Standards Committee of the Acoustical Society of America. He has been appointed to the Ultrasonics Task Force of the National Science Foundation, and has been appointed as a consultant to the National Science Foundation for a period of one year, with an area of service in experimental Research and Development.

* * *

The North Carolina Chapter of the Arthritis Foundation has awarded an \$875 fellowship grant to the medical school to support a student doing arthritis research this summer.

The research will be conducted in the school's Rheumatology Unit under the direction of Dr. Robert A. Turner Jr., assistant professor of medicine.

The student recipient of the fellowship will be named later.

* * *

Dr. Hugh B. Lofland, professor of pathology, has been selected to serve on the editorial board of the *Experimental and Molecular Pathology Journal*.

* * *

Dr. Clark E. Vincent, professor of sociology, spoke on "The Impact of Business-Industry on Marital and Family Health" March 18 during the annual meeting of the Southeastern Council on Family Relations in Tuscaloosa, Ala.

* * *

Dr. Paul M. James Jr., associate professor of surgery, has been named a representative director of section 4-A of the University Association of Emergency Medical Services.

* * *

Dr. James G. McCormick, research associate professor of otolaryngology, spoke on "Sudden Hearing Loss Due to Diving and Prevention with Heparin" during the First Symposium on Fluctuant Hearing Loss, sponsored by the Department of Otolaryngology and Maxillofacial Surgery of the University of Tennessee College of Medicine.

AMERICAN ACADEMY OF ALLERGY

Dr. Susan Coons Dees has been elected vice president of the American Academy of Allergy. She is the first woman to hold a position on the Academy's executive committee.

A graduate of the Johns Hopkins University School of Medicine, and a member of the Duke University since 1939, Dr. Dees is author of 58 articles on various subjects pertaining to allergy.

Listed in *Who's Who in American Women* and *Who's Who in the South*, she served on the White House Conference on Children and Youth in 1960 and is a past-president of the N. C. Pediatric Society and the Southeastern Allergy Association.

Her professional memberships include the Southwestern Society for Pediatric Research, the American Pediatric Society, the American Academy of Pediatrics, the AMA, the Southern Medical Association, and the Medical Society of the State of North Carolina.

Her husband, Dr. John Dees, is a professor of urology at Duke.

JOINT COMMISSION ON ACCREDITATION OF HOSPITALS

At its December meeting in Chicago, the Board of Commissioners of the Joint Commission on Accreditation of Hospitals (JCAH) took action on recommendations with regard to the following:

i. The process of developing a plan concerning future organizational structure, direction, operational mechanisms of the Joint Commission, and other related items.

ii. Joint Commission standards: to make available the recently approved standards for Nonhospital Centers for Ambulatory Health Care and Neighborhood Health Centers.

3. The governing body and medical staff relationships: approval of new language to be added to the *Accreditation Manual for Hospitals* in the following sections — "Governing Body and Management," "Medical Staff," and "Medical Record Services."

4. The modification of the Hospital Accreditation Program's policies on confidentiality.

5. The JCAH policy which presently permits application for survey by a nonaccredited hospital six months after the date of nonaccreditation, in relation to the JCAH/CMA surveys.

6. A new budget of approximately \$6,700,000 for 1974.

Details of these and other actions of the Board will be covered in future editions of the Joint Commission's newsletter *Perspectives*.

New Video Presentation Instructs In Physiologic Changes Affecting Mature Women

The latest video presentation from the Ayerst Laboratories, "Physiology and the Emotions in the Mature Woman," is now available for viewing.

Based on the Symposium on Physiologic Bases for Emotional Disorders in Women, at the New York Academy of Medicine, October 16, 1972, the film presents the diagnostic and therapeutic implications of physiologic changes affecting women in their middle years.

The film is made with Drs. Charles W. Lloyd, Charles E. Flowers, Jr., Robert N. Rutherford, and Judd Marmor. It uses portions of the symposium, office and hospital sequences, animation, and scientific footage.

For more information write to Ayerst Laboratories, 685 Third Ave., New York, N. Y. 10017, Attn: Ayerst Medical Information Service.

Month in Washington

The American Medical Association is playing a leading role in an attempt to establish an American Blood Commission that would assure a national, volunteer supply of blood for transfusions and medical emergencies by December 31, 1975.

At a press conference in the AMA—Washington office, the plan was made public by Richard E. Lerner, M.D., now chairman of the AMA Board of Trustees, and spokesman for the major groups in-

involved in collecting, distributing and using blood.

Other major sponsors of the proposed American Blood Commission include the American National Red Cross, the American Association of Blood Banks, and the Council of Community Blood Centers.

The proposed plan is for a volunteer program controlled at the local level, with medical societies playing a major role. Some 150 national groups with

an interest in a safe blood supply would be members of a commission that would oversee each regional program. The regional programs in turn would guide the activities of blood banks and transfusion facilities in their own area.

Last fall the Administration warned that if the private sector could not reach agreement on a national program, a federally-mandated program would be sought from the Congress. The AMA stepped in and mediated the sharply different approaches advocated by the major blood groups.

The major difference had pitted a for-profit against nonprofit blood supply. In the nonprofit field, the American Association of Blood Banks (AABB) and the American National Red Cross have vied for the leadership role. The nonprofit blood banks—largely hospital units—chiefly have favored a nonreplacement fee for blood as the most dramatic way of attracting donors, whereas the Red Cross traditionally has relied on strictly volunteer blood.

Under the proposed plan, the for-profits would be out in the cold. The hope is that a nonreplacement fee system will not be needed, although it would be permitted.

The AMA-proposed plan has been published in the Federal Register in order to give interested groups time to comment. At a later date HEW will sponsor a conference to consider comments and decide a course of action.

Commenting on the proposal, Dr. Palmer told the news conference it "builds on the strengths of the pluralistic system."

"These partners in the American Blood Commission can communicate the medical necessity of dependable blood supply to the general public from which volunteer donors must come," he said. "The systematic coordinated recruitment of volunteer donors called for by this plan depends on a receptive public attitude."

"By the end of 1975 every blood bank associated with one of the three major blood banking organizations expects to be drawing 100 percent of their blood supply from volunteer donors," Dr. Palmer said.

* * *

The American Medical Association has warned Congress that the legislation before it would tear the health sector as "one vast, monolithic public



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FELLOWSHIP HALL WILL ARRANGE CONNECTION WITH COMMERCIAL TRANSPORTATION.

ality" with the Secretary of Health, Education and Welfare "a health care czar."

Testifying before the Senate health subcommittee, a bill sponsored by Senator Edward M. Kennedy, (D-Mass.), AMA President Russell B. Roth, D., termed the bill "one of the gravest steps to be proposed concerning health care delivery." The measure calls for replacement of Comprehensive Health Planning and Regional Medical Programs by a formal planning system coupled with public utility regulations by state health commissions under HEW supervision. "We are opposed to the creation of public utility type regulatory controls and the planning mechanisms in this and similar measures," Dr. Roth said.

The bill before the Senate health subcommittee calls for a formal system of planning coupled with public utility regulation by state health commissions under the supervision of the HEW Department. It is part of a comprehensive measure, extending certain public health service programs and making sweeping changes in the nature of the present Comprehensive Health Planning and Regional Medical Programs.

"In our view this extreme measure is unwarranted, without justification based on either experience or need. It carries serious potential for impeding a beneficial development of medical care," Dr. Roth said.

He termed the bill an "unprecedented federal involvement in matters which, under our federal system, have traditionally resided in state and local governments.

"We must caution against the imposition of a massive bureaucratic control of the health care system. The expertise within governmental bureaucracy must be questioned. We cannot afford to institute a system which can stifle meaningful competition, innovation, and development of appropriate health care services and facilities. The economic forces inherent in this proposal could defeat the intention of this committee to foster the developments of improvements in our health care delivery system."

A major provision of the legislation would require state health commissions "to determine prospectively rates used for reimbursement purposes for health services of health care providers within the state and regulate all reimbursements if such health care providers made on either a charge, cost, negotiated, or other basis and review such rates at least once a year."

All of the authority ostensibly vested in the state health commissions can ultimately rest in the HEW Secretary, Dr. Roth noted. He asked whether this means the federal government could:

- close down private health care institutions and federal facilities;
- shut a municipal or state hospital; and

—regulate salaries, wages, collective bargaining agreements of health care workers.

"Is the performance of the Secretary of HEW and the Administration so exemplary and so unquestionable that he should be the ultimate repository of the total authority over the entire health care delivery system?" Dr. Roth asked.

The strengths of the present system which have developed in the absence of structured planning should not be overlooked, testified Dr. Roth.

"In our view the contemplated formal system of planning, coupled with the public utility regulation, cannot be justified," Dr. Roth said. "Nor should the extreme governmentally mandated system of planning and regulation be adopted without evidence that such a plan can reasonably be expected to succeed. We believe it is prudent to proceed on an experimental basis so as to determine what mix of voluntary planning together with governmentally required planning proves to be the most effective in specific regions of this country.

"... In view of the potentially irreversible harmful effects of the proposed system upon our health care delivery system, we urge this committee to reject any such proposal."

Dr. Roth was accompanied by James Sammons, M.D., then chairman of the AMA Board of Trustees and now Executive Vice-President designate.

* * *

Congress dealt a mortal blow to the Administration's plan to continue wage-price controls on physicians, hospitals, and nursing homes after April 30.

The Senate Banking Committee voted 11 to 4 against a compromise plan that would give the Administration standby authority to keep controls on some industries after the April 30 cut-off when the controls program expired. The Committee then unanimously voted to kill the Administration program to keep the lids on health while freeing the rest of the economy.

House Banking Committee Chairman Wright Patman (D-Texas), previously had predicted his panel would not move to continue controls.

Barring an unexpected shift in Congressional sentiment, the control program is dead. Health providers, led by the AMA, waged a determined assault on the Administration's program to extend controls in health, promising legal action, and urging lawmakers to drop the entire controls apparatus.

Although Cost of Living Council Director John Dunlop refused to concede defeat, talking bravely of "other options . . . being explored through appropriate legislative channels," most lawmakers agreed that the Banking Committee had sounded the death knoll to the Administration's unusually insistent drive to control the health segment of the economy.

Sen. John Tower (R-Texas), a member of the Banking Committee, said most committee Senators

believed that it is "time to let the marketplace be allowed to work."

* * *

Despite a strong labor-backed move to the contrary, the House easily approved legislation allowing self-employed people such as lawyers and physicians to deduct from federal income taxes up to \$7,500 a year provided it is placed in a qualified pension plan.

The Senate had already approved the provision—part of an overall pension reform bill—making chances of final Congressional enactment and signing into law almost certain.

The current Keogh program limitation on tax deferrals for retirement is \$2,500 not to exceed 10 percent of income. The new provision allows \$7,500 not to exceed 15 percent of income.

Spokesmen for the provision, including the AMA, urged lawmakers to approve on grounds that the cost of living has increased dramatically since the Keogh Law was last liberalized.

The legislation for the first time imposes certain limitations on corporate retirement programs including those for so-called professional service corporations. Tax deferrals will not be allowed on savings that would exceed a pension that brings in more than 75 percent of highest earnings over a three-year period or \$75,000 a year, subject to cost-of-living allowances in the future. A "grandfather-

clause" exempts people eligible for more than \$75,000 based on current compensation and additional period of employment.

* * *

A total of 203 areas have been designated for Professional Standards Review Organization (PSRO's) by DHEW, 21 more areas than tentatively proposed last December. Major change was allowing two larger states—Georgia and Washington—to operate as single PSRO areas.

The final area designations—published in the Federal Register—were handed down after a month-long review of hundreds of comments from physician groups.

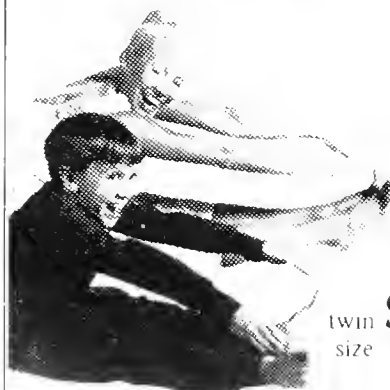
"We have now reached an important milestone in implementing the PSRO program," commented HEW Secretary Caspar Weinberger. "Local physician groups can now take the lead role in establishing PSRO's for the areas we have designated."

The most significant change in the final regulation was naming Georgia and Washington as single PSRO areas. Both states have more than 5,000 physicians, and had been divided into three PSRO sections each. In the earlier proposed regulations, HEW had indicated it would hew to the 2,500-3,000 physician limit for a PSRO area. Many states and the AMA had urged HEW to permit some states with higher physician populations to serve as single PSRO's.

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Other changes included designating as a single area Hawaii, American Samoa, Guam, and the Trust Territories. These Pacific areas had been proposed for two PSRO's.

Increases or decreases in the number of PSRO areas within states accounted for the remaining changes. Texas was increased from 8 to 9 areas; Michigan from 8 to 10; Florida from 8 to 12; California from 21 to 28; and Wisconsin decreased from 20 to 2.

In addition, Illinois from 7 to 8; Indiana from 6 to 7; Maryland from 5 to 7; New York from 14 to 17; North Carolina from 4 to 8; and Ohio, from 9 to 12.

All told, 31 states and territories will serve as single PSRO's 22 as multiple PSRO's.

HEW invited applications for contracts from qualified physician organizations to plan PSRO's, to be in operation of PSRO's on a conditional basis, or to establish statewide organizations to provide support services to local PSRO's.

"We believe that PSRO's which are to be planned, operated, and controlled by private physicians can significantly improve the quality of medical care rendered in institutions to beneficiaries of government health programs," said Weinberger.

"For this reason, we have proposed that PSRO's be expanded to monitor the quality of all services provided under the Comprehensive Health Insurance program in which President Nixon recently submitted to Congress."

The head of the PSRO program said the new Statewide Support Center Plan would give large state medical societies essentially what they sought in their fight for single-state PSRO status.

Henry Simmons, M.D., told AM NEWS that the larger states never intended to do the review and standard setting on a statewide basis. According to Dr. Simmons, those states wished to provide the leadership and support for PSRO in their states. "Now that makes a good deal of sense," the Deputy Assistant Secretary of Health said.

"We see it (the statewide Support Center) as a way in which state organizations can provide very important leadership and very important services centrally, and that makes a lot of sense from our standpoint, from the standpoint of efficiency," Dr. Simmons said. "We see them as providing a very

important role in getting the PSRO program started in their states, using good will and leadership in educating the profession. . . ."

The Statewide Support Center idea was one of the major new announcements in the final PSRO area designation rules.

Dr. Simmons was asked why Texas and other state societies from large population states were turned down in their bid for single PSRO area designations and why Georgia and Washington were picked.

He said Texas is too big and diverse. "There are too many major areas in that state which just don't relate to one area for medical services—thus (it) cannot be designated as a single-state area."

By contrast, according to Dr. Simmons, in both Georgia and Washington "there is a concentration of specialists and a majority of physicians in one particular area—in Georgia, the Atlanta area; in Washington, the Seattle-Takoma-Bremerton area."

Although present PSRO areas might be changed in the future, Dr. Simmons indicated there was little chance that any of the larger states would qualify to join Georgia and Washington as single-state PSRO areas. He said those two states, with more than 5,000 physicians each, were at "the upper limit" of physician population for a PSRO area.

* * *

Within hours after Drs. James Sammons and Richard Palmer, representing the AMA Board of Trustees, pressed a call upon energy czar William Simon, with respect to the effect of gasoline shortages on physicians and their care of patients, Simon wired a statement to all state governors suggesting that they establish a special rule to assure adequate gas for medical personnel and other essential public services.

The statement read in part: "State and local governments may want to consider establishing such a procedure where long lines or early gas station closings could limit the mobility of doctors, nurses, and other medical personnel in providing medical services. Special accommodations also might be considered for those who provide other vital public services."

"I urge your consideration of need for special arrangement to assure gas to all those who perform these essential public services, when it is necessary to their work."

Book Reviews

Chemical and Biological Aspects of Drug Dependence. S. J. Mule, Ph.D. and Henry Brill, M.D. (eds). 561 pages. Price \$35.00. Cleveland, Ohio: CRC Press, The Chemical Rubber Company, 1972.

This sensibly ordered collation of manuscripts by reputable authorities deals with subject matter which is of great concern and urgent necessity to medical practitioners. It is clearly represented as a "reference text," and the editors make no claim of objectivity or special validity beyond what may be inferred by the reputations of the various authors.

Certainly every physician should be as well informed as possible about the effects, both beneficial and harmful, of the chemical agents he prescribes for his patients. Since physicians are granted the exclusive right and responsibility for prescribing most psychotropic drugs that are used or abused, or both, in this country today, there should be sufficient pragmatic concern on the part of physicians for retaining this prerogative—that every care be taken to be well informed, rational and prudent in prescribing the psychotropic agents. This book is a valuable resource for acquiring or updating that special knowledge which is expected of all prescribing physicians.

There are extensive up-to-date references at the end of each section for those who wish to pursue in greater depth specific data or concepts. The classification of the psychotropic drugs of dependence, as presented in this book, approaches a more rational system for clinical applicability than is to be found in most textbooks.

For whatever reasons, which I will refrain from speculating upon here, the fields of "the psychotropic drugs, drug abuse, addiction and dependency" have remained complex and relatively obscure for many years, while other major medical problems have become better understood, managed, or controlled, owing to the dedicated efforts of medical scientists. Perhaps this book represents one small step in the right direction as it attempts to correlate and integrate the presently existing information available on the chemical and biological aspects of drug dependence. I recommend to the editors and the publisher that their next publication of urgent necessity be "The Behavioral and Psychological Aspects of Drug Dependence," to be compiled and edited with the same

professional objectivity as is apparent in the present volume being reviewed.

WILLIAM S. PEARSON, M.D.

Neonatology: Diseases of the Fetus and Infant. Richard E. Behrman (ed). 698 pages. Price \$39.50. St. Louis: C. V. Mosby Company, 1973.

During the past ten years, much new information about newborns has led to dramatic changes in the medical care. *Neonatology*, a multiauthored text, fulfills the need for a comprehensive text incorporating these advances. It is intended for use by physician, nurses, and physicians' assistants who participate in newborn care.

The book is divided into two parts. The first portion, covering the high risk infant, resuscitation in the delivery room, and birth injuries and infections, is very good in content. It provides theoretical and practical guidance for many situations encountered in the newborn period. The book will not, however, serve as a treatment manual for intensive neonatal care. Sections on mechanical assistance to respiration and parenteral nutrition contain insufficient detail for one to use them as the only reference in applying these techniques to patients.

The second portion of the book contains chapters on diseases of the organ systems, metabolism, and jaundice. Organization of these chapters varies with the authors' styles. I think the book could have been improved in having a single scheme of organization. The quality of the chapters varies. For instance, the chapter on renal disease is very useful and has several illustrations, whereas the chapter on gastrointestinal disease is poorly organized, lacks full discussion of some entities, and has no illustrations.

In most chapters the text is not referenced, and as a result the reader is not led directly to other literature on the subject. Although some chapters have categorized bibliographies, many are arranged only alphabetically, an unnecessary deficiency.

The index is inadequate in that several topics discussed in the text are not included in the index, and other topics are indexed incompletely, that is, only one page is given although the topic appears in several places in the text. The incomplete indexing is

serious deficiency, particularly with respect to the book's use for reference purposes.

The entire book could have been better illustrated, and illustrations could have been used advantageously in several chapters where none are used, particularly the chapter on "Diseases of the Skin."

Excellent charts of normal laboratory values and drug doses are appended.

In summary, I would recommend this book as a starting place for those wishing to have a knowledge of neonatology. Although there are deficiencies in individual chapters, *Neonatology* is the best single source incorporating the modern approach to neonatology.

The price seems high considering the small number of illustrations.

WILLIAM A. SMITHSON, M.D.

In Memoriam

Joseph Wentworth Coxe, M.D.

Dr. Joseph Coxe, 57, was fatally injured in an automobile accident April 5, 1973. He had practiced psychiatry in Asheville for ten years, associated with Highland Hospital, and was later in private practice.

A native of Roanoke, Virginia, Dr. Coxe graduated from the University of Virginia Medical School in 1942. Internship was at Roper Hospital, Charleston, S. C. He was resident psychiatrist at Chestnut Lodge, Rockville, Md., Washington School of Psychiatry and Washington Psychoanalytic Institute.

During WW II he served in the U.S. Army with the rank of Lieutenant.

The Buncombe County Medical Society expresses its deep sense of loss of their fellow and extends its sympathy to the widow, the former Jane Jewell, and the two daughters, Susan and Sally of the home.

Whereas, we of the Society feel keenly the loss of a skillful and dedicated member by an accidental and untimely death, therefore be it

RESOLVED, that a copy of this writing be made a part of the minutes of the Buncombe County Medical Society and a copy sent to the widow. Furthermore, that a copy be forwarded to the North Carolina Medical Society for publication in the JOURNAL of the North Carolina Medical Society.

BUNCOMBE COUNTY MEDICAL SOCIETY

Charles Darwin Thomas, M.D.

Charles Darwin Thomas, 71, died at his home unexpectedly September 17, 1973. He had retired in 1971 from the Medical Directorship of Western North Carolina Sanatorium.

He was a native of Danville, Indiana, and received his M.D. degree from the University of In-

diana. His internship and residency were at Indianapolis City Hospital where, in his third year, he was hospitalized for tuberculosis at Trudeau Sanatorium at Saranac Lake, N. Y. Here he was both a patient and part-time staff member from 1928-1930.

Dr. Thomas was employed by the W.N.C. Sanatorium in 1930. He was appointed to the Staff of the State Sanatorium at Sanatorium, N. C. in 1937. Previously he had worked for the State as a consultant and in case finding. In 1933, he skin tested 10,000 children in Buncombe County. In 1946 he became Medical Director of W.N.C. Sanatorium.

When Streptomycin became available, Dr. Thomas and his staff participated in one of the first studies on its effectiveness. After resistance to the drug developed, his research was directed to various drug combinations. His work was an integral part of the U.S. Public Health Service Studies at the time.

Dr. Thomas was past president of the Southern Tuberculosis Association and of the N. C. Thoracic Society. He was the author of many articles on tuberculosis.

He had the unusual satisfaction of seeing a tremendous decline in the tuberculosis rate during his career. In 1930 the mortality in North Carolina from TB was 72/100,000 population; at his retirement the mortality was 2.5/100,000.

Dr. Thomas was a most highly respected authority in his field and was a source of countless help to the doctors in this area and to the legion of patients that flowed through W.N.C. Sanatorium during his tenure. He was a warm and friendly man and will be sorely missed by all who knew him.

He is survived by his widow, the former Dorothy Drake, two sons, Lt. Col. Charles D. Thomas, Jr., and Raymond B. Thomas, Kernersville, N. C., and a daughter Judith Ann. Therefore, be it

RESOLVED that a copy of this writing be made a part of the minutes of the Buncombe County Medi-

cal Society and a copy sent to the NORTH CAROLINA MEDICAL JOURNAL for publication.

BUNCOMBE COUNTY MEDICAL SOCIETY

William Christian McGuffin, M.D.

Dr. William C. McGuffin died at his home October 27, 1973 at the age of 63 years, following a long illness.

Dr. McGuffin was born in Joliet, Illinois. He received his M.D. degree from Loma Linda Medical School in 1934, and he served an internship at Nashville General Hospital.

He entered practice in Asheville in 1937 and was associated with Dr. Alex White in the practice of obstetrics. He later confined his practice to pediatrics, gradually abandoning obstetrics.

During WW II he served in the Medical Corps

at Camp Claiborne, Louisiana. He was Chief of Staff of St. Joseph's Hospital in 1958 and was a member of the Buncombe County Medical Society, North Carolina Medical Society, and American Medical Association.

He is survived by his widow, the former Karen Reeves, a son, William T. McGuffin of Chicago, and a daughter, Mrs. Rachel Ray of Asheville.

Whereas, he was a popular pediatrician and affectionately known to his patients as "Dr. Mac" and will be sorely missed by his associates and former patients, therefore be it

Resolved that this account be transcribed in the minutes of the Buncombe County Medical Society, a copy sent to his widow, and one to the JOURNAL of the North Carolina Medical Society for publication.

BUNCOMBE COUNTY MEDICAL SOCIETY

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NORTH CAROLINA

Medical Journal

THIS ISSUE: Variability of Prescription Drug Prices, Donald M. Hayes, M.D., and John F. Whalley, M.D.; The Etiology of Diabetic Microangiopathy. A Review of the Recent Literature, Charles W. Smith, Jr., M.D.; Recent Developments on the Insanity Defense, R. L. Rollins, Jr., M.D.; Insect Sting Allergy in Children, Claude A. Frazier, M.D.

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Variability of Prescription Drug Prices

Donald M. Hayes, M.D., and John F. Whalley, M.D.*

In the early 1960s price differences among food stores selling similar merchandise were recorded.^{1, 2} Shortly thereafter, similar price variations were found to exist for drugs.³ In these studies economic factors were the chief causes. Prices were higher in pharmacies which only filled prescriptions and in those which were primarily owned than in those operated by "chain" corporations selling a wide variety of merchandise. Hastings and Kunnes⁴ introduced a new dimension into this subject by having a well dressed white and a poorly dressed black college student present prescriptions for 100 units of 0.25 mg Lanoxin at 40 urban pharmacies in Kansas City. He concluded that race and appearance of the patient may influence the price of a prescription. In this study, non-economic variables were added to the list of price influences.

The importance of these factors was denied by Braucher and Kotler⁵ who randomly sampled 36 pharmacies in Atlanta. Each was visited by four consumers, well dressed and shabbily dressed white

and black college students, who presented prescriptions for 12 Darvon Compound 65 pulvules. In examining the variables of race, attire, and store type, they found a significant price difference to occur only among different types of stores.

This study has attempted to expand on these two earlier reports and to clarify the influence of non-economic variables on the price of prescription drugs.

METHODS

This study was conducted in Forsyth County, North Carolina. Located in the Piedmont region of the state, it is dominated by the city of Winston-Salem, which has a population of approximately 150,000.⁶ The city is the long-time home of such large companies as R. J. Reynolds Industries and Hanes Corporation. In recent years Western Electric Company, Wake Forest University, Joseph Schlitz Brewing Company, and Westinghouse Corporation have moved to the county. The urban area is bordered by a beltway created by Silas Creek Parkway and U. S. 52. Outside this central zone the county is rural, with occasional suburban developments and multiple unit apartment complexes scattered among corn and tobacco fields.

The pharmacies chosen for the study were selected and grouped

primarily according to their business location and the characteristics of their primary consumer. Representative stores were chosen from each of the major shopping districts. They included the downtown business area of Winston-Salem, Model Cities Project area, hospital pharmacies, suburban shopping centers, suburban community drug stores, and rural community drug stores.

The differences between the various pharmacies are described in Table 1. If the merchandise sold included, for example, magazines, books, cosmetics, sports equipment, and household goods, in addition to prescription and over-the-counter (o-t-c) drugs, the store was classified as "variety." The hospital pharmacies dispense only prescription drugs and were labeled "apothecary," while the stores labeled "drug only" also sell o-t-c medicines. Pharmacies were classified as belonging to a "chain" if four or more stores were under the same management or if they were members of a national chain of stores.

Consumer Population Density (CPD) was estimated by comparing the location of the store to the general shopping patterns of county residents. If the store was located in a major business district, then the CPD was "high." However, if the shopper had to make special efforts

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Table 1
Attributes of Different Types of Pharmacies in this Study

	Type Merchandise Sold	Ownership	Consumer Population Density	Consumer Income	Degree of Competition	Categories of Consumer Not Seen Often
Downtown	Variety	Chain	High	Mixed	High	None
Model City	Drug Only	Private	High	Low	Moderate	All White M & F
Hospital Pharmacy	Apothecary	Private	High	Mixed	High	None
Suburban Shopping Center	Variety	Chain	High	Mixed	High	None
Suburban Community	Variety	Private	Moderate	High	Moderate	All Black M & F
Rural Community	Variety	Private	Low	Low	Low	All Black, Radical White M & F

to reach the pharmacy, then the CPD was rated "low."

Values for consumer income were assigned according to accepted national standards.⁷ The degree of competition was estimated by the location of the store, its special appeal to a particular consumer group, and the mobility of the population it served. Thus, the Model Cities pharmacies were judged "moderate" because they were located on the periphery of the downtown shopping district and appealed to black consumers who lived in the area. The suburban community stores were raised from their expected "low" rating to "moderate" because their customers were highly mobile. The category of consumer who rarely visited a particular pharmacy was emphasized in the last column. Three stores were assigned to each category except for those in the Model Cities area and two hospital pharmacies. One hospital located in the Model Cities area, sold prescription drugs only for Medicare stamps and was excluded from the study.

A standard prescription was written for one-hundred 0.25 mg tablets of Lanoxin (with two refills) by six physicians at the North Carolina Baptist Hospital and randomly distributed among the "consumers." Each pharmacy was presented with the standard prescription by a member of each of the seven categories of consumer: male, female, black, white, well dressed, "radical," and rural-appearing. The participants were employed with the idea that they would look and act naturally in the consumer roles they were asked to portray. Accordingly, only four university students were selected.

The remainder were older adults with various occupations, interests, and levels of education. Should the pharmacist question their need for Lanoxin, all "consumers" were instructed to reply that their physician was treating heart disease.

Prior to the "consumer" portion of the study, each pharmacy was queried by telephone by a physician who asked for the price of the standard prescription. Then each of the 12 "consumers" visited each of the 16 pharmacies at random over a three-week period, filling 192 prescriptions. The purchases were made in cash. Without specific instructions, the "consumers" were also asked to observe the activities of the pharmacist and his employees during their visit.

RESULTS

The various pharmacies are located in Forsyth County as follows: 1, 2, and 3 are in the downtown business area; 4 and 5 are the Model Cities Project area; 6 and 7 are hospital pharmacies; 8, 9, and 10 are in suburban shopping centers; 11, 12, and 13 are suburban community drug stores; and 14, 15, and 16 are in the rural areas (Table 2).

Prescription prices are presented in Table 2. Owing to a confusion of names, one prescription was filled with an estrogen preparation, and for another prescription only 50 tablets were dispensed without explanation.

Several observations may be made by inspecting the data. No two consumers paid the same amount for all 16 prescriptions. The price remained identical for all consumers in four stores, while the range was

greater than \$1 in four stores. In several stores the telephoned price did not indicate what amount the consumer would be charged.

An analysis of variance employing Duncan's New Multiple Range test was performed. No significant difference existed among the seven consumer groups; however, among pharmacies prices varied significantly ($p < 0.0005$). The frequency of dispensing error was not computed because of the small size of the sample.

DISCUSSION

This study was designed to explore subtle differences in the economic price variables of race and attire. The quoted telephone price was independent of these influences. Another variable was examined, pairing male and female "consumers." Overall, the data agree with those of Braucher and Kotler and show no evidence that race or attire influenced the price of prescription drugs. They agree with the work of others in that between different types of stores prices for a standard prescription were markedly different.

As this study is larger than the two previously reported, it also showed a wide range in prescription prices occurring within a single pharmacy. On a purchase of \$2 the price varied randomly by more than 50 cents in seven stores and by as much as \$2 in two additional stores. This variation was striking. The reasonable explanation for this observation was human error by the pharmacist or his employees. Whatever the cause, the consumer/patient

Table 2
Pharmacy

CONSUMER	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	TOTAL
Well Dressed																	
Male	2.50	1.43	1.50	1.60	1.75	1.25	2.00	1.27	1.48	1.69	3.15	1.40	1.75	2.25	2.25	2.25	29.52
Female	2.50	1.43	1.36	1.60	2.06*	1.75	2.00	1.12	1.20†	1.69	3.15	1.90	2.50	2.25	2.25	1.75	30.51
Medical																	
Male	2.50	1.43	1.49	2.50	1.75	2.25	2.00	1.12	1.48	1.60	3.15	1.90	1.75	2.25	2.25	2.25	31.67
Female	2.50	1.43	1.39	2.50	1.75	2.25	2.00	1.12	1.48	1.69	3.15	1.90	2.50	2.25	2.25	2.00	32.16
White Collar																	
Male	2.50	1.43	1.39	2.50	1.75	1.50	1.40	1.27	1.48	1.69	3.15	1.90	2.50	2.25	2.00	2.00	30.71
Female	2.60	1.43	1.36	2.61	1.75	1.65	2.00	1.27	1.48	2.25	3.15	1.90	1.75	2.25	2.00	3.00	32.45
White Well Dressed																	
Male	2.50	1.43	1.25	2.50	1.75	2.25	1.50	0.75	1.48	1.69	3.15	1.90	2.00	2.25	2.00	2.00	30.40
Female	2.50	1.43	1.39	0.60	1.75	2.25	2.00	1.27	1.48	2.25	3.15	1.90	1.75	2.25	2.25	1.75	29.97
Medical																	
Male	2.50	1.43	1.29	2.50	1.75	2.25	1.50	1.27	1.48	1.60	3.15	1.90	1.75	2.25	2.00	2.00	30.62
Female	2.50	1.43	1.39	1.50	1.75	2.25	2.00	1.12	1.48	1.69	3.15	1.90	1.75	2.25	2.00	2.25	30.41
White Collar																	
Male	2.50	1.43	3.25	2.50	1.75	2.00	2.00	1.27	1.48	1.69	3.15	1.90	2.00	2.25	2.25	2.00	33.42
Female	2.50	1.43	1.48	1.60	1.75	2.25	2.00	1.12	1.48	2.25	3.15	1.90	2.00	2.25	2.25	2.00	31.41
Total Paid	30.10	17.16	18.54	24.51	21.31	23.90	22.40	13.97	17.48	21.78	37.80	22.30	24.00	27.00	25.75	25.25	—
Average Paid	2.51	1.43	1.55	2.04	1.76	1.99	1.87	1.16	1.46	1.82	3.15	1.86	2.00	2.25	2.16	2.10	—
Age	0.10	0	2.00	2.01	0.31	1.00	0.60	.52	0	0.65	0	0.50	0.75	0	0.25	1.25	—
Telephone Price	2.50	1.43	1.39	2.00	1.75	2.25	2.00	1.27	1.48	1.79	3.15	1.78	2.00	2.25	2.00	2.00	31.04
Trojan Preparation Supplied																	
Tablets Supplied																	

the loser, or winner, depending on the direction of the error.

There has been growing evidence that the consumer/patient is developing increased awareness of his susceptibility to exploitation in the pharmaceutical marketplace. *Consumer's Report* recently highlighted this issue, and Richard J. Klein,^{8,9} economics editor, presented their observations to the American Pharmaceutical Association at its annual meeting. In this manner the national pharmaceutical leadership has demonstrated their recognition of the consumer's discontent.

Whatever reforms the pharmacist might propose, the cost of a prescription is not determined solely by him. The prescribing physician and the manufacturer also must be included in the marketplace. While the American Medical Association has

stated its concern over the price and quality of drugs for several years, a recent survey by Lowy, Lowy, and Warner¹⁰ discouragingly showed a "limited knowledge of the cost of antimicrobial agents by practicing physicians."

The "consumers" in the study unknowingly activated a potential mechanism that operates to protect the consumer/patient. Several of the physicians writing prescriptions for this study were questioned by pharmacists who were aware of an unusually high frequency of prescriptions for Lanoxin. Such interaction was not expected to be observed in a medical center, although it does occur more frequently in private practice. The further development of these relationships, both formally and informally, should be encouraged. The quality of medical

care can be improved only by further cooperation of various health professionals.

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Medicines are often adulterated for the sake of a colour. Acrid and even poisonous substances are, for this purpose, sometimes introduced into those medicines which ought to be most bland and emollient. Ointment of elder, for example, is often mixed with verdegrieffe to give it a fine green colour, which entirely frustrates the intention of that mild ointment. Those who wish to obtain genuine medicines should pay no regard to their colour.—*William Buchan: Domestic Medicine, or a Treatise on the Prevention and Cure of Diseases by Regimen and Simple Medicines, etc., Richard Folwell, 1799, p. 439.*

The Etiology of Diabetic Microangiopathy— A Review of the Recent Literature

Charles W. Smith, Jr., M.D.

IN recent years many studies have shed much light on the theories of the etiology of diabetes mellitus and its associated angiopathy. These studies have also raised many questions. Today 85 percent of people with diabetes mellitus die of the consequences of microangiopathy rather than from ketoacidosis, insulin shock, and other related conditions. Further, it has been shown that "tightly controlled" diabetics develop vascular problems as readily as insulin independent diabetics.¹ Thus, if control of hyperglycemia affects vessel involvement, it is at best a minor improvement. Siperstein² failed to demonstrate a relationship between basement membrane thickening and blood glucose levels. Therefore, another physiologic phenomenon must be at work to cause, or to contribute to, diabetic microangiopathy. The consequent hyperglycemia may well be only a symptom of a more basic physiologic derangement.

The meaning of the term diabetic angiopathy is confusing and is therefore a problem in the study of the disease. It is widely known that diabetes predisposes one to early atherosclerosis, large vessel disease, as

well as to the so-called specific small vessel involvement which primarily affects the arterioles. Thus, when one refers to diabetic angiopathy does one mean the so-called specific small vessel lesions, or does one mean collectively the small vessel and large vessel involvement? In the light of recent evidence, it is quite possible that a single physiologic phenomenon, contributed to by environmental factors, can account for both types of vessel involvement. For purposes of this review, I refer only to small vessel disease, since this is the only type specific for diabetes. The most common organ lesions are nephropathy, retinopathy, iridopathy, coronary disease, and gangrene; however, the organ lesion most specific to diabetes mellitus is the nephropathy or Kimmelstiel-Wilson lesion of the kidney. Diabetic neuropathy has long been considered secondary to involvement of the vasa nervorum, but this consideration has been questioned when nonvascular nervous anomalies were present at the start of acute juvenile diabetes.³⁻⁵ In addition, PAS positive hyalinization of arterioles, having the same electron micrographic picture as the diabetic retinopathy and the Kimmelstiel-Wilson lesions, has been demonstrated in the stomach, intestines, skin, striated muscle, placenta, and the inner

ear.⁶ Besides these morphologic changes, demonstrations of increased capillary fragility and increased permeability of striated muscle capillaries to small ions, such as sodium and iodide, having been noted.⁶

Clinical studies of diabetic retinopathy have shown that at the start of clinical diabetes mellitus, ophthalmoscopic examination results are normal. However, there is a positive correlation between diabetic retinopathy and the duration of the disease since, after 15 to 25 years from the onset of the disease, most patients showed signs of retinopathy. In 1955 Lundbaek⁷ reported that four percent of the diabetic population at the start of the disease had significant retinopathy; since most of these patients were elderly the results are inconclusive. Furthermore, some light and electron microscopic studies of acute juvenile onset diabetes have shown no changes in the basement membranes of arterioles until three to five years after symptoms appeared.⁸⁻¹⁰ Siperstein compared striated muscle capillaries of overt diabetics, normals, and potential diabetics (offspring of two diabetic parents). His study showed basement membrane thickening in eight percent of normals, 99 percent of overt diabetics and 53 percent of the potential "p

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diabetic" group. Also, according to the same study, there is no increase in basement membrane thickness in secondary acquired diabetes. Siperstein¹² concludes that, since hyperglycemia cannot cause this vessel involvement, microangiopathy precedes or causes diabetes mellitus. This concept was supported by Kinoshita¹¹ who showed that children having diabetes of recent onset have increased pulse velocity secondary to decreased small vessel distensibility. Williamson,¹² however, failed to reproduce Siperstein's work, presumably using the same methods and materials.

It is true that microangiopathy precedes clinical diabetes mellitus, but what causes the small vessel involvement? Colt¹³ proposes that since patients whose diabetes is controlled by tolbutamide (which stimulates insulin secretion) show increased incidence of cardiovascular death, insulin could be the cause of angiopathy; he does not, however, cite any studies to support this idea.

Recently several investigators have proposed that a derangement in growth hormone levels is the cause of diabetic vessel involvement.^{14, 15} Beaumont et al¹⁴ and Lundbaek et al¹⁵ have found that growth hormone plasma levels are increased by a mean of three times that of nondiabetics and that, instead of following the normal diurnal variation, these levels fluctuate wildly during a 24-hour period. Furthermore, these levels do not return to normal when the diabetes is brought under control. Additionally, a significant improvement has been demonstrated in many cases of diabetic retinopathy following hypophysectomy.¹⁵ Beaumont¹⁴ proposes that hypersecretion of growth hormone raises levels of sorbitol to increase intracellularly and that the resulting osmotic load causes

chronic irritation, ultimately leading to the basement membrane thickening seen by use of the electron microscope; because the cell membrane (except that in the liver) is impermeable to sorbitol, growth hormone plasma levels increase and result in osmotic imbalance.¹⁴ Since growth hormone causes increased use of fats for energy production and, by feedback, causes inhibition of enzymes of the glycolytic pathway, the conversion of glucose to glucose-6-phosphate is inhibited and results in increased cellular glucose. This excess of glucose is shunted via an aldose reductase to sorbitol and leads to abnormal buildup of sorbitol in the cells. Beaumont concludes that "raised plasma growth hormone in juvenile diabetes mellitus, response to exercise in a well controlled diabetic, the inhibitory effects of hypophysectomy on the progress of retinopathy, and the normalization of skin capillary fragility after hypophysectomy points to a role for growth hormone in diabetic angiopathy."¹⁴ This suggestion is supported by Kinoshita¹⁶ who has shown that diabetic neuropathy correlates with levels of polyol accumulation in the cells and osmotic swelling of the nerve fibers. It is further suggested that since increased sorbitol in cells may cause vessel involvement, inhibition of sorbitol formation by an aldose reductase inhibitor, such as trimethylene glutamate, may have clinical usefulness in the study of microangiopathy (now under study by Lundbaek).

One can postulate that the derangement in growth hormone levels is present before clinical diabetes mellitus and detectable angiopathy. One can also postulate that continued insult to the cells results in progressive thickening of the basement membrane of arterioles. Furthermore, one might assume that

if the basic lesion produces increased growth hormone, the small and large vessel disease may have a single cause which works by a different mechanism. Small vessel disease resulting from osmotic insult to endothelial cells, and large vessel disease caused by prolonged increase in plasma fatty acids could be a result of increased levels of growth hormone. Additional studies undoubtedly will produce further insight into these important questions.

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Take of common decoction, ten ounces; Venice turpentine, dissolved with the yolk of an egg, half an ounce; Florence oil, one ounce. Mix them.

This diuretic clyster is proper in obstructions of the urinary passages, and in cholicky complaints, proceeding from gravel.—*William Buchan: Domestic Medicine, or a Treatise on the Prevention and Cure of Diseases by Regimen and Simple Medicines, etc., Richard Folwell, 1799, p. 446.*

Recent Developments on the Insanity Defense

R. L. Rollins, Jr., M.D.*

THE insanity defense is ordinarily chosen only when the possibility of conviction and the severity of the possible penalty outweigh the disadvantages. This has been especially true in North Carolina because of the restrictions on defendants who are acquitted on this basis. Until recently the law provided that "no person acquitted of a capital felony on the ground of mental illness, and committed to the (state) hospital . . . shall be discharged therefrom unless an act authorizing his discharge be passed by the General Assembly. No person acquitted of a crime of a less degree through a capital felony and committed to the (state) hospital . . . shall be discharged therefrom except upon an order from the Governor" (N. C. Gen. Stat., Sec. 122-86). As far as I could ascertain, no person was ever released from the state hospital under these provisions.

A 1972 decision of the North Carolina Supreme Court liberalized the restrictions placed on the probationary release or discharge of those patients acquitted as not guilty by reason of insanity (*In re Tew*, 280 N. C. 612, 1972). The 1973 General Assembly changed the General Statutes to conform to this decision (N. C. Gen. Stat., Sec. 122-86).

The 1974 General Assembly (N. C. Gen. Stat. Sec. 122-84.1) provided the following: that those persons acquitted on the grounds of mental illness must have a hearing, and; that if the court finds that the defendant-respondent is mentally ill and dangerous to himself and to others, it shall order him committed to a psychiatric facility for not more than 90 days. The defendant thereafter is to be treated as any other committed patient. If the court finds that the defendant is not mentally ill and imminently dangerous to himself or to others, it shall order his discharge. Thus, a defendant who is found not guilty by reason of insanity is to be treated as a mentally ill person, rather than as a criminal.

In the past there may have been some confusion between criteria of competency to stand trial and the test of criminal responsibility. "In determining a defendant's capacity to stand trial, the test is whether he has the capacity to comprehend his position, to understand the nature and object of the proceedings against him, to conduct his defense in a rational manner, and to cooperate with his counsel to the end that any available defense may be interposed" (*State v. Propst*, 274 N. C. 62, 161 S.E. 2d 560, 1968; *State v. Jones*, 278 N. C. 259, 179 S.E. 2d 433, 1971).

Therefore, one may be mentally ill and still be able to meet the test

of competency. In fact, different levels of competency might be considered in the case of the defendant who sits quietly in the courtroom while his attorney enters a plea of guilty to breaking and entering, as opposed to a complicated income tax evasion case in which the defendant must demonstrate a great degree of cooperation with his attorney. Also, in looking at the defendant's ability to cooperate with counsel, the defendant may be competent in relation to one attorney and incompetent in relation to another, depending on the skill and motivation of counsel. It is my feeling that, in most cases, it is to the defendant's advantage to return to court to dispose of the legal charges as soon as possible.

The test for mental responsibility in North Carolina is the M'Naughten rule: "the capacity of defendant to distinguish between right and wrong at the time of and in respect to the matter under investigation" (*State v. Propst*, 274 N. C. 62, 161 S.E. 2d 560, 1968). This test becomes an issue only if the defendant elects to present the insanity defense. It may be to his advantage to plead not guilty, to plead self defense, or to bargain for a lesser penalty.

Contrary to popular belief, the M'Naughten rule does not restrict psychiatric testimony, and the judge generally allows the psychiatrist to say as much as he wishes as long

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is relevant to the case.¹ It remains for the jury to determine whether the defendant should be held responsible for his actions.

In practice, the state hospital may recommend to the solicitor that the charges be nol-prossed and may suggest a treatment plan (judicial commitment to a state hospital or outpatient treatment) if the hospital considers the patient to have a significant mental illness. Increasing involvement of mental health professionals in consultation with law enforcement and judiciary, in pretrial and presentence evaluations, may

provide other alternatives.

Because the insanity defense is rarely used and since many criminal defendants have court-appointed attorneys, few attorneys gain extensive experience with the insanity defense. Increasing use of the Public Defender may result in the individual attorney's having more opportunity to present the insanity defense. Reinstatement of the death penalty in North Carolina may also increase the frequency of the insanity defense (Amendment of N. C. Gen. Stat., Sect. 14-17 by the 1974 General Assembly).

In spite of these changes, it seems likely that the insanity defense will remain a last resort. Few defendants (especially those who might really qualify) eagerly embrace the stigma of insanity. Confinement in a mental hospital is not necessarily more appealing than incarceration in a correctional setting. Also, one receives a definite sentence and release date when convicted, but he must risk the uncertainty of release if the insanity defense is used successfully.

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However trifling (gargles) may appear, they are by no means without their use. They seldom indeed cure diseases, but they often alleviate very disagreeable symptoms; as parchedness of the mouth, foulness of the tongue and fauces, etc. they are peculiarly useful in fevers and sore throats. In the latter, a gargle will sometimes remove the disorder; and in the former, few things are more refreshing or agreeable to the patient, than to have his mouth frequently washed with some soft detergent gargle.

One advantage of these medicines is, that they are easily prepared. A little barley-water and honey may be had any where; and if to these be added as much vinegar as will give them an agreeable sharpness, they will make a very useful gargle for softning and cleansing the mouth.

Gargles have the best effect when injected with a syringe.—*William Buchan: Domestic Medicine or a Treatise on the Prevention and Cure of Diseases by Regimen and Simple Medicines, etc., Richard Folwell, 1799, p. 453.*

Insect Sting Allergy in Children

Claude A. Frazier, M.D.

CHILDREN are inquisitive, and they often venture into close proximity to stinging and biting insects. Many children are stung each year. Most reactions to insect stings and bites are mild. Less often, severe reactions occur which necessitate prompt medical care. The importance of allergic reactions to insect stings and bites is emphasized by the fact that more deaths occur each year from insect stings and bites than from snake bites.¹ Therefore, an awareness of the spectrum of symptoms and adverse effects of insect stings and bites is important.

A variety of symptoms may result from insect stings, depending upon the amount of venom injected, the presence or absence of hypersensitivity and, to a lesser degree, the location of the lesion. Several types of reactions can occur:²

Normal reaction: At the time of the sting, the patient has a sharp pinprick sensation which lasts for several minutes. A small red area appears at the sting site and is gradually surrounded by a whitish zone and a red flare. A wheal forms and, as it subsides, gives way to irritation, itching, and heat. All traces of the sting usually disappear within a few hours.

Local reaction: This reaction is manifest by an unusual amount or duration of swelling, or both. Any degree of swelling, even involvement of an entire limb, is considered a local reaction when it is continuous with the sting area. The symptoms

may begin immediately, or after an interval of time.

Superimposed infection: Unlike bees, wasps and hornets are scavengers and are likely to transmit infection with their venom. Local reactions may be complicated by infection which presents as a cellulitis, hours or days after the sting occurred.

Toxic reactions: When a colony, or swarm of bees or wasps, is disturbed or threatened, numerous insects may sting a single victim. Even when no sensitivity exists, the amount of venom injected can cause systemic poisoning and may lead to death. The clinical findings in these instances include gastrointestinal symptoms such as diarrhea and vomiting, drowsiness, edema without urticaria, headache, fever, and unconsciousness.

Recovery may follow attacks, but death is not unusual. It is estimated that approximately 500 stings, within a short time, inject a lethal dose of poison. However, survival has been reported following more than 2,000 stings.³

Generalized allergic reaction: Many varied symptoms may occur in the sensitive child. The first symptom may be a dry, hacking cough, followed by a sense of constriction in the throat or chest, swelling and itching about the eyes, massive urticaria, sneezing, and wheezing, a rapid pulse, a fall in blood pressure, pallor or blushing of the skin, and a sense of uneasiness. Generalized papular urticaria, marked regional adenopathy, and petechial hemorrhages have also been reported.

The most severe reactions consist of one or more of the following symptoms: constriction of the throat or chest, or both, shortness of breath, asthma, cyanosis, abdominal cramps, diarrhea, nausea, vomiting, chills and fever, vertigo, laryngeal stridor, shock, loss of consciousness, involuntary bowel or bladder action, or both, and bloody, frothy sputum.

Delayed reaction: It should not always be assumed that if the reaction can be safely controlled for approximately one hour, the danger of illness is over. Some patients have delayed reactions to stings, manifested by fever, lymphadenopathy, malaise, headache, urticaria, and polyarthritides. These symptoms usually occur ten to 14 days after the actual sting and they may occur after the first sting.

Psychological reaction: Occasionally, in the absence of hypersensitivity, a person has an anxiety reaction from sheer fright following a sting. The patient may feel faint, perspire, and may have an increased pulse rate. It is hazardous to assume that a person is having a psychological reaction, because if hypersensitivity exists, death could occur before the proper therapy can be initiated. It is often necessary to evaluate and provide supportive therapy to patients with psychological reactions until an allergic reaction is excluded.

Fatal reaction: Deaths reported to be caused by bee stings or other Hymenoptera are infrequent, probably accounting for no more than 2 each year in the United States. The true incidence is probably far

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water. Only when death results from a toxic reaction to the stings by a large number of insects, is the cause of death clearly evident. In other cases, the sting can be overlooked or viewed as incidental, and the cause of death is reported as a coronary thrombosis, heart failure, shock, or some other allergy with laryngeal edema, bronchospasm, and shock.

Usually the severe symptoms begin within two to ten minutes. Thus, it is important for patients with hypersensitivity to insect stings or bites to avoid potentially lethal insects. The patient should be prepared to recognize signs of early hypersensitivity reactions and be able to administer emergency self-treatment. Hyposensitization should be used when the patient has severe insect hypersensitivity.

Two groups were identified in a recent survey of 78 children.⁴ The first consisted of 29 children with late local reactions manifest as areas of swelling, several inches in diameter, usually confined to the head, foot, face, or entire limb. The other group consisted of 49 children having a history of one or more of the following symptoms: wheezing, urticaria, shock, unconsciousness, dyspnea, angioedema, and generalized itching as a result of insect stings (Table 1).

Of the total series of patients, the age range was from two to 16 years. Sixty-seven percent were between five and eight years of age. It is believed that this age group, normally aggressive and inquisitive, is more likely to tantalize stinging insects. It was noted that 57 percent had generalized reactions, and the remaining

Table 2
Age in Relation to Type of Reaction^a

Age Group (Years)	Total No. of Patients	Generalized Reactions		Local Reactions	
		No. of Patients	Percent	No. of Patients	Percent
2-4	14	8	57	6	43
5-8	29	17	59	12	41
9-12	23	15	65	8	35
13-16	12	9	75	3	25

Table 3
Sites of Stings^a

Site of Sting	Total No. of Patients	Generalized Reactions (Percent)	Local Reactions (Percent)
Feet	24	16-67	8-33
Head	21	12-57	9-43
Hands	14	7-50	7-50
Arms	9	4-44	5-56
Legs	6	3-50	3-50
Trunk	2	2-100	0

^a Some of these patients reported more than one sting.

43 percent had local reactions. In the 13 to 16 age group, 75 percent had generalized reactions and the other 25 percent had local reactions. Thus, there seems to be a correlation between the increase in age and the degree of hypersensitivity (Table 2).

An analysis of the kinds of insects responsible for these reactions revealed that the honey bee and the yellow jacket stings were the most common. Comparisons of the sites and types of reactions showed that a high incidence of severe reactions occurred in children who were stung on the feet (Table 3). Most stings occurred in the summer, especially in the month of July.

Each patient or his parents were asked how soon the reaction followed the sting. It was reported that most severe hypersensitivity reactions occurred within thirty minutes of the sting. This suggests that if a severe reaction is not evident within thirty minutes, the chances of a generalized reaction are remote.

Sixty-three percent of the children had a history of other allergies. These consisted of allergic rhinitis, asthma, eczema, and conjunctivitis. Twenty-two percent of the children had drug allergies (Table 4).

Most of the patients estimated that they had been stung approximately once each year. Of the 49

generalized reaction patients, 18 recalled local reactions to the last sting, ten had generalized reactions to both stings, and 16 had no untoward reactions to any prior sting.

THE REACTION-PRONE CHILD

Is it possible to predict which children are most likely to be stung? If so, which type of reaction is most likely to occur? The outstanding characteristics and circumstances in which the patients in this series were stung are as follows: The sting-prone child is a white male, between the ages of five and eight, who is playing in clover or near flowers, following a heavy July shower. The child is bare-footed and bare-headed and is dressed in gaily colored, coarse clothing. Sweet-smelling hair oil keeps his wayward locks in place. His energies are being expended in locating a honey bee and chasing it

Table 1
Patients With Symptoms of Generalized Reaction^a

Type of Reaction	No. of Patients	Percentage
urticaria	36	73
Shock (generalized)	33	67
Angioedema	26	53
Difficulty breathing	12	24
Shock and vomiting	8	16
Shock	2	4

^a Some of these patients reported more than one sting.

Table 4
Reaction in Relation to Associated Allergy^a

Associated Allergy Symptoms	Generalized Reactions	Localized Reactions
Perennial nasal allergy	9	16
Asthma	6	3
Asthma & nasal allergy	4	3
Hay fever	1	2
Asthma & eczema	1	2
Conjunctivitis	0	2

Table 5
Type of Reaction Expected^a

	General Reaction	Local Reaction
Sex	male	male
Race	white	white or Negro
Month	July	July
Age	teen-age	pre-school
Type of attire	no shoes	shoes
Type of insect	hornet honey bee	yellow jacket
Site of sting	feet	arms
Frequency of stings	1 per year	1 per year
Reactions from preceding stings	none	local
Drug allergy	possible	probable
Personal atopic history	possible	very probable

about the garden in an attempt to catch it.

A generalized reaction is most likely to occur in a teen-age male who has a positive family history of allergy, but who is not necessarily atopic. He has approximately one sting each year. The patient's generalized reaction is usually caused by the same insect type, despite a history of no adverse reactions to previous stings. Thus, on a July day, a teen-age male steps on a honey bee or a hornet and a generalized hypersensitivity reaction follows (Table 5).

INSECT STING PREVENTION

The physician should have a knowledge of insect habits and should insure that the patient with insect hypersensitivity is aware of relevant information. The usual location of insect nests is important. Insects are more aggressive in the vicinity of their nests. The patient should be warned about this source of heightened risk of exposure. While playing or doing yardwork, the patient having an allergy to stings should be cautious, especially during the summer months. Patients are advised to rid the environment of flowers and to rid the lawn of clover. It should be stressed that insects are more likely to sting on bright warm days, especially when they are disturbed during the process of gathering nectar. Avoidance of perfumes, hair sprays, hair tonics, sun lotions, and other attractants is helpful. Bright colors and flowery print fabrics should also be avoided. The most suitable articles of clothing are those made from smooth

fabrics. Clothing should be light in color—white, green, tan, and khaki. Shoes are a must at all times! The wearing of shoes is the most important preventive measure to be taken. Long trousers, gloves, and head coverings will prevent many severe reactions. Children should not be allowed to eat such foods as water-

Table 6
Remember the 3 A's

Adrenalin
Antihistamine
Aminophylline

(Steroids, I.V. fluids, plasma expanders, and oxygen may also be necessary.)

Table 7

Prevention of Insect Stings

- Do's**
- Do wear shoes
 - Do wear smooth fabrics
 - Do wear light colors
 - Do wear long trousers, gloves, and head coverings
- Don'ts**
- Don't go barefooted
 - Don't wear rough fabrics
 - Don't wear gaily colored clothing
 - Don't use perfumes, hair sprays, hair tonics, and sun lotions
 - Don't eat popsicles and watermelons outside

Table 8

Managing Insect Sting Reactions

1. Immediate treatment is necessary for acute reactions to insect stings.
2. Remember the three A's—Adrenalin, Antihistamine, and Aminophylline, if bronchoconstriction is not relieved.
3. Desensitization should be given to all patients having a severe reaction, by a person knowledgeable in this field.
4. An insect kit should be prescribed for a patient who has had an acute reaction.
5. A list of preventive measures should be given to the patient and or parents.
6. All children should wear shoes when they are out of doors.

melon and popsicles out of doors since the sweet smell of these food attracts insects.

TREATMENT OF ACUTE REACTIONS TO INSECT STINGS (Table 6)

At the present time, the treatment of choice appears to be the prompt administration of epinephrine 1:1000.¹ Epinephrine 1:1000 0.2-0.3 ml should be injected subcutaneously as soon as possible, and in extreme cases, intravenously. The drug can be given at intervals of ten to 30 minutes as indicated, until the vital signs are stabilized. The child should be watched closely and his blood pressure should be taken every few minutes, for early detection of shock. A tourniquet should be placed proximal to the site of the sting, whenever possible, and the epinephrine should be injected above the tourniquet. Antihistamines and steroids can be given either by mouth or parenterally. It may also be necessary to administer aminophylline if bronchoconstriction is a problem.

LONG-TERM MANAGEMENT OF INSECT STING REACTIONS

Insect sting kits are available by prescription for patients who have had severe reactions. This kit should be carried at all times; immediate treatment is essential for prevention of death from severe reactions.

Patients with severe insect sting hypersensitivity should be desensitized to the offending insect or insects. This treatment can be hazardous and should be done by a specialist in allergy.

Important aspects of prevention and management of insect hypersensitivity are summarized in Tables 7 and 8.

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Editorials

THE SPRING MEETING OF THE EXECUTIVE COUNCIL

For the second year since completion of the New Headquarters Building, the Executive Council convened in Raleigh on May 5, 1974 for the usual meeting, preliminary to the Annual Convention in Pinehurst. The cool, rainy day helped the golf and fishing enthusiasts to better concentrate on the business at hand.

Among the items considered were more than a dozen resolutions from county Societies for reference to the House of Delegates and for action by that body after open consideration by Reference Committees. Major issues involved were Professional Service Review Organizations, new rules and requirements by the Joint Committee on Accreditation affecting hospital staff procedures, and the need for expanding activities on the legislative and public relations fronts. Members wishing to be heard on any or all of these topics should attend the Reference Committee sessions at Pinehurst.

Purchase of additional property adjoining the Headquarters Building parking lot was approved. This action was deemed appropriate in view of possible future additions to the building.

Medpac reported an increase in sustaining membership to 70, and presented a resolution asking all Executive Council members to become sustaining members of Medpac. Further, the Medpac resolution proposes that the members of the House of Delegates join Medpac and adopt a resolution to the AMA House of Delegates, proposing that its members join Medpac.

The Council received a proposal from Mr. William Henderson, formerly Director of the Medical Commission, representing three North Carolina Foundations—Duke, Reynolds, and Kate B. Reynolds—to develop a plan of financial subsidy to aid hospitals to resolve emergency room problems by the employment of full-time physicians. Presently, of 140 North Carolina general hospitals, 12 have full-time emergency room coverage, 14 have coverage on nights and weekends, and an additional 5 on weekends only. The Council approved the proposition in principle pending further study and report.

Josephine Newell, Chairman of the Annual Convention Commission, reported more than 1,500 responses to a questionnaire concerned with the Annual

Meeting. The larger number indicated preference for Pinehurst as a meeting place, more than half chose a May date rather than September, and a majority expressed a willingness to meet a registration fee for a quality program of Continuing Education.

J. S. R.

PROBLEM-ORIENTED RECORDS

In the past few years there has been much interest in what is currently called the problem-oriented record (POR)—some would call it a fad—and this new method of record keeping has the backing of some very bright and energetic medical leaders, including some here in our state. The idea of identifying the patient's problems as one goes through the initial examination process, then dealing with them in a positive way during the period of patient-physician interaction sounds good, especially when all of us can recall fruitless searches through records to find how a patient's major problems had been dealt with, or had resolved naturally. Most of what one has read about the POR thus far has been favorable, often enthusiastic, although there have been some calls for caution. In a recent article (*N Engl J Med* 290:829-833, 1974) Robert Fletcher cites some of the pertinent literature and presents his own evaluation of the traditional source-oriented record (SOR), as opposed to the POR, in auditing medical records, a task all of us are going to have to be concerned with.

Fletcher took the histories of four patients with complex illnesses and cast them into both the POR and SOR formats. After suitable independent review to see whether the records were fair examples of the two forms, 36 house officers at two teaching hospitals were asked to read them. The time it took to read each record once and answer ten factual questions on its content was recorded, as were the accuracy of the answers and the proportion of major medical care errors recognized independently. No significant differences were detected. Thus, Fletcher feels that if the POR is adopted, it should be for reasons other than facilitating medical audit.

In an accompanying editorial, Dr. Neelon from Duke expresses some of his concerns about the study, especially his feeling that the POR may be good discipline, leading to a better record—something not judged in Fletcher's study, since the PORs and

SORs he used were equal in content, though different in form. Dr. Neelon's apparent view of the POR—a more structured record—would certainly seem reasonable, though perhaps harder to test than Fletcher's measurement of the POR's utility for audit procedures. A new format like the POR, being promoted by an energetic chief, would seem likely to produce more information than the usual record, but would it be better than the SOR's being systematically and constantly reviewed by the same energetic chief? Or could the same results be achieved by requiring each house officer to write up an institution's experience with some clinical condition? At the end of such efforts most people start to keep better records, having seen how bad most records are, even in "good" institutions. The answer, dear reader, probably lies within ourselves, not within our record formats—we remain our own chief problems.

Emergency Medical Services



A MOBILE SYSTEM OF ACUTE CARDIAC CARE

Joseph Robert Anthony, M.D., Chief of
Cardiology

St. Mary's Hospital, Waterbury, Connecticut

In spite of the advances of coronary care units (CCUs), more than 300,000 victims of heart attacks continue to die annually before reaching a hospital. This situation has led to an extension of the CCU into the community in the form of mobile units. One such mobile unit (Heartmobile) has been operating in Waterbury, Connecticut, for more than a year, receiving an average of two calls a day, 60 percent of them cardiac.

The Heartmobile is manned by a CCU nurse, emergency room nurse, and two paramedics, all with special, intensive training in emergency medicine and acute coronary care. Initially, there was also a resident physician. The Heartmobile is activated by calling 573-1313; a trained dispatcher alerts the personnel by radio signal and dispatches the unit. More than 50 percent of the homes in the area can be reached in five minutes. After arrival of the unit, the patient's electrocardiogram is telemetered back to the hospital, and the patient is given medication and

PRESCRIBING INFORMATION Antiminth (pyrantel pamoate) Oral Suspension

Actions. Antiminth (pyrantel pamoate) has demonstrated anthelmintic activity against *Enterobius vermicularis* (pinworm) and *Ascaris lumbricoides* (roundworm). The anthelmintic action is probably due to the neuromuscular blocking property of the drug.

Antiminth is partially absorbed after an oral dose. Plasma levels of unchanged drug are low. Peak levels (0.05-0.13 µg/ml.) are reached in 1-2 hours. Quantities greater than 50% of administered drug are excreted in feces as the unchanged form, whereas only 7% or less of the dose is found in urine as the unchanged form, the drug and its metabolites.

Indications. For the treatment of ascariasis (roundworm infection) and enterobiasis (pinworm infection).

Warnings. *Usage in Pregnancy:* Reproduction studies have been performed in animals and there was no evidence of propensity for harm to the fetus. The relevance to the human is not known.

There is no experience in pregnant women who have received the drug.

Precautions. Minor transient elevations of SGOT have occurred in a small percentage of patients. Therefore, this drug should be used with caution in patients with pre-existing liver dysfunction.

Adverse Reactions. The most frequently encountered adverse reactions are related to the gastrointestinal system.

Gastrointestinal and hepatic reactions: anorexia, nausea, vomiting, gastralgia, abdominal cramps, diarrhea and tenesmus, transient elevation of SGOT.

CNS reactions: headache, dizziness, drowsiness, and insomnia. Skin reactions: rashes.

Dosage and Administration. *Children and Adults:* Antiminth Oral Suspension (50 mg. of pyrantel base per 5 ml.) should be administered in a single dose of 11 mg. of pyrantel base per kg. of body weight (or 5 mg./lb. maximum total dose 1 gram). This corresponds to a simplified dosing regimen of 1 cc. of Antiminth per lb. of body weight. (One teaspoon = 5 cc.)

Antiminth (pyrantel pamoate) Oral Suspension may be administered without regard to ingestion of food or time of day; and purging is not necessary prior to, during, or after therapy. It may be taken with milk or fruit juices. Because of limited data on repeated doses, no recommendations can be made.

How Supplied. Antiminth is available as a pleasant tasting orange-flavored suspension which contains the equivalent of 50 mg. pyrantel base per ml., supplied in 60 cc. bottles.

ROERIG 
A Division of Pfizer Pharmaceuticals
New York, New York 10017

WORMS BLITZED



A single dose of Antiminth (1 cc. per 10 lbs. of body weight, 1 tsp./50 lbs. — maximum dose, 4 tsp.=20 cc.) offers highly effective control of *both* pinworms and roundworms.

Antiminth has been shown to be extremely well tolerated by children and adults alike in clinical studies.* Pleasantly caramel-flavored, it is non-staining to teeth and oral mucosa on ingestion... doesn't stain stools, linen or clothing.

One prescription can economically treat the entire family.

ROERIG *Pfizer*

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Pinworms, roundworms controlled with a single, non-staining dose of

ANTIMINTH[®]
(pyrantel pamoate)

equivalent to 50 mg pyrantel/ml.

ORAL SUSPENSION

Please see prescribing information on facing page.

treatment by instruction from a physician at the hospital until the patient's condition is stable. Cardiopulmonary resuscitation is started if necessary. The patient is transported only after his cardiovascular system has stabilized.

Further information, including survival statistics and cost analysis, is given in "The Heartmobile—A Mobile System of Emergency Cardiac Care," (1973) a publication prepared by the author and

available from him at St. Mary's Hospital, 56 Franklin Street, Waterbury, Connecticut 06702.

Abstracted by LEWIS BECKER, M.D.

From "Emergency Medicine Today," *AMA Commission on Emergency Medical Services, Volume 3 No. 4, John M. Howard, M.D., Editor. Original article can be obtained from the American Medical Association, 535 North Dearborn Street, Chicago, Illinois 60610.*

Correspondence

POISONS THAT KILLED

To the Editor:

In the April 1974 issue of the NORTH CAROLINA MEDICAL JOURNAL there is an article on page 227 entitled "Poisons that Killed: An Analysis of 300 Cases." I commend the authors on their paper. However, I would like to point out some facts and conclusions from the drug abuse perspective.

Both in the statistical table and in the discussion, the authors referred to morphine deaths. No attempt was made to suggest that there is a probability that 90 percent of these deaths were due to the injection of heroin. The authors may have supposed that the physicians of North Carolina are aware that heroin is metabolized, and reported at autopsy as morphine. I have no such faith in this awareness of our physicians and would like you to point out the evidence that the vast majority of these young males are heroin addicts.

I concur in the conclusion that one must see these deaths as accidental. Although the heroin addict has a substantial self-destructive element in his personality, the specific timing of the injection that leads to death is not usually related to suicidal intent. The authors might have discussed briefly the controversy as to whether these deaths are, in truth, overdoses or whether they represent a kind of sudden death seen in heroin addicts that is postulated to have an allergic cause similar to anaphylactic shock.

Inasmuch as the authors are interested in preventing "accidents," it might be pointed out that the best prevention for heroin deaths would be a well-run drug abuse program.

For the State Toxicology Laboratory to make some attempt to distinguish between an accidental overdose and a deliberate overdose, in the single drug

and combined drug listings, might be important for the physicians of the state. For example, the combination of Mellaril and Doriden, presumably taken by an individual who is mentally ill, might result in accidental or suicidal death. Only "careful psychological autopsy" might reveal the difference.

Again, let me commend the authors on the excellent emphasis upon alcohol as the leading drug abuse and the leading cause of death among drug abusers. I do believe the emphasis on accidental death is somewhat different because of the manner of reporting in other parts of the country.

R. W. WHITENER, M.D.
Greensboro, N. C.

Dr. Fatteh replies:

Dr. Whitener is perfectly correct in saying that a large majority of the deaths we reported as "morphine" deaths were caused by injections of "heroin." We feel, though, that almost every physician in the state is aware of this fact. As to the statement that "the vast majority of these young males are heroin addicts," we would like to stress that deaths among novice drug abusers are not uncommon.

Every attempt is made, during the investigation of a fatality, to determine the precise manner of death and this includes, whenever necessary, a "psychological autopsy" also. As far as heroin deaths are concerned, "accidental" manner of death is a rule. I have not come across a single case in which suicide use of heroin was substantiated. Death is not due to overdose of heroin in a great majority of cases. It is believed that many fatalities result from hypersensitivity reactions. These facts indicate the "accidental" nature of death.

The State Toxicology Laboratory does attempt

Whenever possible, to identify the drugs thought to be involved in a fatality. The conclusion regarding the manner of death is drawn after complete consideration of investigative, autopsy, and toxicological findings. No doubt, determination of precise quantities of drugs, especially in the cases of combined use of alcohol and barbiturates, does help in separating suicides from accidents. The overall effect of a well-planned drug abuse program on society will be good, but it has to be a very involved, elaborate program to make an impact as a preventive measure. Fortunately, the drug scene is changing for the better. In North Carolina, as in the nation, the numbers of deaths from heroin have been dropping. In North Carolina, heroin, alone or in combination with other drugs, caused 17 deaths in 1971, sixteen in 1972, and five in 1973.

ABDULLAH FATTEH, M.D., PH.D., LL.B.
Associate Chief Medical Examiner
Chapel Hill, N. C.

INSECT BITES

To the Editor:

Again, this year I am compiling case reports of allergic reactions to biting insects, i.e., mosquitoes, fleas, gnats, kissing bugs, bedbugs, chiggers, black flies, horseflies, sandflies, deerflies, and the like. I am also interested in reactions to the Imported and Southern Fire Ants.

I would like for physicians to supply me with case reports of those patients who have had reactions to such insect bites. Please include in your reports the type of reaction; complications, if any; the age, sex, and race of the patient; the site of the bite(s); the season of the year; the immediate symptoms; the skin test results; desensitization results, if any; and any associated allergies. Anyone who is interested may send this information to the following address:

CLAUDE A. FRAZIER, M.D.
4-C Doctors' Park
Asheville, N. C. 28801

Bulletin Board

NEW MEMBERS of the State Society

Acns, Leon Ashby, M.D. (OTO), 1700 S. Tarboro St., Wilson 27893
Barl, Frederick Joseph, M.D. (PD), 720 Grove St., Salisbury 28144
Bar, Elizabeth Renwick (Student), Box 2734, Duke Med. Ctr., Durham 27710
Bla, Frank Rudolph, M.D. (P), 1308 Highland Dr., Washington 27889
Ble, J. Montgomery, M.D. (U), (Renewal), 2227 Wood-
lawn Ave., Burlington 27215
Bisp, Linda Alice (Student), 19 Town House Apts., Durham 27705
Blam, Lillian Ruth, M.D. (PD), Duke Med. Ctr., Durham 27710
Blum, Dan William (Student), 918 Exum St., Durham 27701
Boven, Wm. Frederick, III, M.D. (IM), N. C. Mem. Hospital, Chapel Hill 27514
Buey, Edward George (Student), 10 Lebanon Circle, Durham 27705
Bures, Romulo Ernesto, M.D. (IM), N. C. Mem. Hosp., Chapel Hill 27514
Bongley, Gary Edward (Student), 4429-A Ryan St., Durham 27704
Benson, Jonathan Robert Tolme, M.D., 1917 White Plains Rd., Chapel Hill 27514
Bie, Avvocato, Victor Alberto, M.D. (Intern-Resident), Box 275, Raleigh 27611

Eldridge, Frederic Louis, M.D. (IM), N. C. Mem. Hosp., Chapel Hill 27514
Forcica, Mary Ann (Student), Box 2764, Duke, Durham 27710
Fox, Gary Norman (Student), Duke Hospital, Durham 27710
Fox, Raymond Morris, Jr., M.D. (OBG), 615 College St., Jacksonville 28540
Furman, Richard Warren, M.D. (WGS), State Farm Road, Boone 28607
Gable, Walter DeLay, M.D. (PTH), Onslow Mem. Hosp., Jacksonville 28540
Glascok, Frank Blackwell, M.D. (R), 1172 Huntsmoor Dr., Gastonia 28052
Grossman, Herman Lewis, M.D. (R), Duke, Box 3834, Durham 27710
Hamilton, Buford Lindsay, Jr., M.D. (GP), 709 W. End Ave., Statesville 28677
Hamilton, Gene Thomas, M.D. (ORS), 125 Lee St., Route 9, Greenville 27834
Harrell, Lonnie Clayton, III, M.D. (Intern-Resident), 408 Colony Woods Dr., Chapel Hill 27514
Hughes, Claude LeBernian, Jr., (Student), Box 2799, Duke, Durham 27710
Jarrett, David Lincoln, M.D. (ORS), 9 All Souls Crescent, Asheville 28803
Kingdon, Henry Shannon, M.D. (IM), N. C. Mem. Hosp., Chapel Hill 27514
Khot, Prakash Nilkonth, M.D. (Intern-Resident), 2131 S. 17th St., Wilmington 28401
Laclergue, Edward Gregory, M.D. (GP), 213 Riverside Dr., N. Wilkesboro 28659
Lesesne, Henry Roby, M.D. (IM), N. C. Mem. Hosp., Chapel Hill 27514
Leslie, John Bruce (Student), Box 2811, Duke, Durham 27710

Lloyd, Stephen Carroll (Student), 4111 Toroella St., Durham 27704
 Lohavichan, Choomsang, M.D. (IM), 2431 Vandevere Ave., Fayetteville 28304
 Lutman, George Benton, M.D. (PTH), 3284-C Turtlepoint Dr., Fayetteville 28305
 Marsigli, Adolfo Hector, M.D. (ORS), Tau Valley Estates, Apt. W-1, Rocky Mount 27801
 Mattern, William Douglas, M.D. (IM), N. C. Mem. Hosp., Chapel Hill 27514
 McGinnis, James Wm., Jr., (Student), Box 2799, Duke, Durham 27710
 McLaurin, Lambert Paschal, Jr., M.D. (IM), N. C. Mem. Hosp., Chapel Hill 27514
 Mintz, Rudolph Ivey, Jr., M.D. (OBG), 3219 Carey Rd., Apt. 2-B, Kinston 28501
 Naga, Ahmed Hady, M.D. (R), Duplin Gen. Hosp., Kenansville 28349
 Ngo, Corazon, M.D. (IM), Box 538, Kenansville 28349
 Noble, John, M.D. (IM), N. C. Mem. Hospital, Chapel Hill 27514
 Olsen, Kenneth Geo., M.D. (AN), 400 Carman Ave., Jacksonville 28540
 Omer, Syed, M.D. (N), 19 Staff Circle, Broughton Hosp., Morganton 28655
 Pfister, Wm. Charles (Student), Box 2847, Duke, Durham 27710
 Prendes, Jose Luis, M.D., 106 King Richard Ct., Jacksonville 28540
 Proctor, Camilla Allyn, M.D. (IM), Rt. 6, Box 23, Chapel Hill 27514
 Rhodes, Herbert Paul, M.D. (R), Valdese Gen. Hosp., Valdese 28690
 Schatz, Richard Alan (Student), 802 Vickers Ave., Durham 27701
 Simrel, Kermit Oscar, Jr., (Student), 3040 Wedgedale Dr., Durham 27702
 Smith, Robert Lee, M.D. (PTH), 236 Wrenn Ave., Mt. Airy 27830
 Snow, Joseph Robert (Student), Box 2851, Duke, Durham 27710
 Steiner, Alton Louis, M.D. (IM), N. C. Mem. Hospital, Chapel Hill 27514
 Sullivan, Robert Joseph, Jr., M.D. (IM), 306 Highland Dr., Chapel Hill 27514
 Taylor, Britton Edgar, M.D. (OBG), 1612 Doctors Circle Dr., Wilmington 28401
 Teti, Joseph Michael, M.D. (GP), Box 242, Roaring Gap 28668
 Thakur, Veda Nand, M.D. (ORS), 14th and Chestnut Sts., Lumberton 28358
 Trofater, Kenneth Frank, Jr., (Student), Box 2865, Duke, Durham 27710
 Tucker, Landrum Sylvanius, Jr., M.D. (Intern-Resident), 313 Woodhaven Road, Chapel Hill 27514
 Walden, Burt Marcus Noland, M.D. (P), 718 S. Fifth Ave., Wilmington 28401
 Watts, Hugh Boyd, M.D. (Renewal), (ORS), Granite Quarry 28072
 Wells, Samuel Alonzo, Jr., M.D. (GS) Duke, Durham 27710
 Wilkinson, Sarah Frances (Student), 301 Swift Ave., Apt. 19, Durham 27705
 Willis, Henry Stuart Kendall, III (Student), Box 2874, Duke, Durham 27710

WHAT? WHEN? WHERE?

In Continuing Education June 1974

("Place" and "sponsor" are listed only where these differ from the place and group or institution listed under "for information.")

In North Carolina June 20-22

Mountain Top Assembly
 Place: Waynesville Country Club, Waynesville
 For Information: R. Stuart Roberson, M.D., P. O. Box 307, Hazlewood 28738

Rondomycin (methacycline HCl)

CONTRAINDICATIONS: Hypersensitivity to any of the tetracyclines

WARNINGS Tetracycline usage during tooth development (last half of pregnancy to early years) may cause permanent tooth discoloration (yellow-gray-brown), which is more common during long-term use but has occurred after repeated short-term courses. Enamel hypoplasia has also been reported. Tetracyclines should not be used in this group unless other drugs are not likely to be effective or are contraindicated. Usage in pregnancy (See above WARNINGS about use during tooth development). Animal studies indicate that tetracyclines cross the placenta and can be toxic to the developing fetus (often related to retardation of skeletal development). Embryotoxicity has also been noted in animals treated early in pregnancy.

Usage in newborns, infants, and children (See above WARNINGS about use during tooth development).

All tetracyclines form a stable calcium complex in any bone-forming tissue. A decrease in fetal bone growth rate observed in prematures given oral tetracycline 25 mg/kg every 6 hours was reversible when drug was discontinued.

Tetracyclines are present in milk of lactating women taking tetracyclines. To avoid excess systemic accumulation and liver toxicity in patients with impaired renal function, reduce usual total dosage and, if therapy is prolonged, consider serum level determinations of drug. The anti-anabolic action of tetracyclines may increase BUN. It is not a problem in normal renal function. In patients with significantly impaired function, higher tetracycline serum levels may lead to azotemia, hyperphosphatemia, and acidosis.

Photosensitivity manifested by exaggerated sunburn reaction has occurred with tetracyclines. Patients apt to be exposed to direct sunlight or ultraviolet light should be so advised, and treatment should be discontinued at first evidence of skin erythema.

PRECAUTIONS If superinfection occurs due to overgrowth of nonsusceptible organisms, including fungi, discontinue antibiotic and start appropriate therapy.

In venereal disease when coexistent syphilis is suspected, perform darkfield examination before therapy and serologically test for syphilis monthly for at least four months.

Tetracyclines have been shown to depress plasma prothrombin activity; patients on anticoagulant therapy may require downward adjustment of their anticoagulant dosage.

In long-term therapy, perform periodic organ system evaluations (including bio renal, hepatic).

Treat all Group A beta-hemolytic streptococcal infections for at least 10 days. Since bacteriostatic drugs may interfere with the bactericidal action of penicillin, avoid giving tetracycline with penicillin.

ADVERSE REACTIONS Gastrointestinal (oral and parenteral forms): anorexia, nausea, vomiting, diarrhea, glossitis, dysphagia, enterocolitis, inflammatory lesions (with local overgrowth) in the anogenital region.

Skin: maculopapular and erythematous rashes, exfoliative dermatitis (uncommon). Photosensitivity is discussed above. (See WARNINGS).

Renal toxicity rise in BUN, apparently dose related. (See WARNINGS).

Hypersensitivity: urticaria, angioneurotic edema, anaphylaxis, anaphylactoid purpura, pericarditis, exacerbation of systemic lupus erythematosus.

Bulging fontanels, reported in young infants after full therapeutic dosage, have disappeared rapidly when drug was discontinued.

Blood: hemolytic anemia, thrombocytopenia, neutropenia, eosinophilia.

Over prolonged periods, tetracyclines have been reported to produce brown-black cross-colored discoloration of thyroid glands; no abnormalities of thyroid function studies known to occur.

USUAL DOSAGE Adults—600 mg daily, divided into two or four equally spaced doses. More severe infections: an initial dose of 300 mg followed by 150 mg every six hours; 300 mg every 12 hours. Gonorrhea: In uncomplicated gonorrhea, when penicillin is contraindicated, Rondomycin (methacycline HCl) may be used for treating both males and females in the following clinical dosage schedule: 900 mg initially, followed by 300 mg q.i.d. for a total of 5.4 grams.

For treatment of syphilis, when penicillin is contraindicated, a total of 18 to 24 gram Rondomycin (methacycline HCl) in equally divided doses over a period of 10-15 days should be given. Close follow-up, including laboratory tests, is recommended. Eaton Agent pneumonia: 900 mg daily for six days.

Children—3 to 6 mg/lb/day divided into two to four equally spaced doses.

Therapy should be continued for at least 24-48 hours after symptoms and fever have subsided.

Concomitant therapy Antacids containing aluminum, calcium or magnesium impair absorption and are contraindicated. Food and some dairy products also interfere. Give one hour before or two hours after meals. Pediatric oral dosage forms should not be given with milk formulas and should be given at least one hour prior to feeding.

In patients with renal impairment (see WARNINGS), total dosage should be decreased by reducing recommended individual doses or by extending time intervals between doses.

In streptococcal infections, a therapeutic dose should be given for at least 10 days. **SUPPLIED** Rondomycin (methacycline HCl) 150 mg and 300 mg capsules, syrup containing 75 mg/5 cc methacycline HCl.

Before prescribing, consult package circular or latest PDR information.



WALLACE PHARMACEUTICALS
 CRANBURY, NEW JERSEY 08512

Rev. I

July 8-13

Annual Duke Medical Post Graduate Course
Place: Atlantis Lodge, Atlantic Beach, North Carolina
Program: designed primarily for the generalist, but with sufficient variation to appeal to the interest of the internist and the pediatrician. Conferences and lectures will be given in the morning; afternoons and evenings will be left free for recreational activities.
Fee: \$85, payable in advance. Course limited to 75 participants.
Credit: A certificate of attendance will be given. Program acceptable for 30 accredited hours by AAFP.
For Information: W. M. Nicholson, M.D., P. O. Box 38088, Duke University Medical Center, Durham 27710

July 29-August 2

Annual Beach Workshop: Selected Topics in General Internal Medicine
Sponsors: Bowman Gray, Duke, and UNC Schools of Medicine, in conjunction with the Medical University of South Carolina
Place: St. Johns Inn, Myrtle Beach, South Carolina
Fee: \$100
For Information: Emery C. Miller, M.D., Associate Dean for Continuing Education, Bowman Gray School of Medicine, Winston-Salem 27103

September 6-7

Annual Meeting of the North Carolina Chapter of the American Academy of Pediatrics and The North Carolina Pediatric Society
Place: Pinchurst Hotel and Country Club
For Information: Mrs. John McLain, Executive Secretary, 3209 Rugby Road, Durham 27707

September 18-19

Annual Angus M. McBryde Perinatal Symposium
Fee: \$50.00
For Information: George Brumley, M.D., Division of Perinatal Medicine, P. O. Box 2911, Duke University Medical Center, Durham 27710

September 20-21

Walter L. Thomas Symposium on Gynecologic Malignancy and Surgery
Program: The two day symposium will be clinically oriented with the main emphasis on "Ovarian Cancer" and "Difficult Office Gynecology." Invited guest speakers include Dr. J. Donald Woodruff, Baltimore, Maryland; Dr. Herbert Buchsbaum, Iowa City, Iowa; and Dr. J. Taylor Wharton, Houston, Texas.
Credit: AAFP credit applied for.
For Information: W. T. Creasman, M.D., Director of Gynecologic Oncology, P. O. Box 2079, Duke University Medical Center, Durham 27710

October 4

Forsyth County Heart Association
Place: Babcock Auditorium, Bowman Gray School of Medicine, Winston-Salem
Fee: \$15.00
For Information: Mrs. Katherine Cox, Forsyth County Heart Association, 2046 Queen Street, Winston-Salem 27103

October 20-22

Annual Joint Meeting of the North Carolina-South Carolina Societies of Ophthalmology and Otolaryngology
Place: Asheville Hilton Inn, Asheville, N. C.
Sponsor: The North Carolina Society of Ophthalmology and Otolaryngology
For Information: Banks Anderson, Jr., M.D., Secretary-treasurer, P. O. Box 3802, Duke University Eye Center, Durham 27710

October 28-November 1

Radiology Postgraduate Course
Place: Southampton Princess Hotel, Southampton, Bermuda
Program Chairman: Richard G. Lester, M.D., Professor and Chairman of Radiology, Duke University Medical Center. Guest speakers will include: Robert G. Fraser, M.D., Professor and Chairman of Radiology, McGill

University Medical School, Montreal, Canada; John A. Evans, M.D., Professor and Chairman of Radiology, Cornell University Medical College; William B. Seaman, M.D., Professor and Chairman of Radiology, Columbia University College of Physicians and Surgeons, New York, N. Y.; Harold G. Jacobson, M.D., Professor and Chairman of Radiology, Albert Einstein College of Medicine (MHMC), Bronx, New York; and David H. Baker, M.D., Director of Radiology, Babies Hospital, Professor of Radiology, Columbia University College of Physicians and Surgeons, New York, N. Y. Subject matter will cover Pediatric and Adult Radiology of the Chest, Genitourinary Tract, Gastrointestinal Tract and Musculoskeletal System.

Fee: \$200

Credit: Twenty-three hours AMA "Category One" accreditation

For Information: Robert McLelland, M.D., Department of Radiology, Box 3808, Duke University Medical Center, Durham 27710

November 15-16

Anesthesiology Fall Seminar

Place: Charlotte Memorial Hospital Auditorium

Fee: \$40.00

For Information: Dr. H. A. Ferrari, Chairman, Department of Anesthesiology, Charlotte Memorial Hospital, P. O. Box 2554, Charlotte 28201

In Contiguous States

June 17-19

PSRO For Hospital Management

Place: The Marriott, Atlanta, Georgia

Fee: ACHA affiliates—\$225; nonaffiliates—\$275

For Information: American College of Hospital Administrators, 840 North Lake Shore Drive, Chicago, Illinois 60611

September 30 & October 1

Tennessee Valley Medical Assembly annual meeting

For Information: Thomas L. Buttram, M.D., Chairman, Tennessee Valley Medical Assembly, Whitehall Medical Center, 960 E. Third Street, Chattanooga, Tennessee 37403

October 5-8

Southern Psychiatric Association annual meeting

Place: The Homestead, Hot Springs, Virginia

For Information: Mrs. Annette Boutwell, P. O. Box 10387, Raleigh 27605

Items submitted for listing should be sent to: WHAT? WHEN? WHERE?, P. O. Box 8248, Durham, N. C. 27704, by the 10th of the month prior to the month in which they are to appear.

News Notes from the—

BOWMAN GRAY SCHOOL OF MEDICINE WAKE FOREST UNIVERSITY

Dr. Manson Meads, Wake Forest University vice president for medical affairs, has been named director of the Medical Center — the Bowman Gray School of Medicine and North Carolina Baptist Hospital.

The appointment was announced recently by Francis E. Garvin of Wilkesboro, chairman of the recently established joint administrative board of the Medical Center.

Dr. Meads was nominated as the Medical Center's first full-time director by the joint administrative board. The nomination received the unanimous ap-

proval of the trustees of Wake Forest University and the trustees of Baptist Hospital.

As director, Dr. Meads will serve as chief executive officer of the Medical Center and will be responsible for its overall direction. He will be responsible directly to the Medical Center board for the execution of duties delegated to the board by the two trustee bodies.

The responsibilities include the formulation of policies relating to the Medical Center, and planning for its future needs and growth.

Dr. Meads will continue as vice president for medical affairs. Overall authority for the two institutions will continue to be held by Dr. Richard Janeway, dean of the medical school, and John E. Lynch, chief executive officer of the hospital.

* * *

The 73 members of the medical school's senior class have been awarded internship appointments for 1974-1975.

They will serve their internships at 41 hospitals in 25 states, the District of Columbia, and one foreign country. Eighteen members of the class will remain at Baptist Hospital for their training.

The seniors received the M.D. degree May 27 during commencement exercises on the Wake Forest University campus. The commencement speaker was Dr. Alvin M. Weinberg, director of the Office of Energy Research and Development.

* * *

Three members of the medical school's faculty will be promoted to the rank of professor, effective July 1.

They are: Dr. John P. Gusdon, Jr., obstetrics and gynecology; Dr. Robert N. Headley, medicine; and Dr. Milton Raben, radiology.

They are among 18 Bowman Gray faculty members for whom faculty appointments were announced by Dr. Richard Janeway, dean.

Promoted to the rank of associate professor were: Dr. Alexander A. Birch, anesthesia; Dr. Thomas E. Clark, community medicine (sociology); Dr. Robert J. Cowan, radiology; Dr. Louis S. Kucera, microbiology; Dr. Dixon M. Moody, radiology (neuroradiology); Dr. G. Joseph Poole, radiology (neuroradiology); Dr. John D. Tolmie, anesthesia; and Dr. Nancy O'N. Whitley, radiology.

Receiving promotions to assistant professor were: Dr. Edward S. Beason, surgery (plastic surgery); Dr. James E. Crowe, radiology; Dr. John W. Denham, community medicine; Dr. Kenneth E. Ekstrand, radiology (radiologic physics); Thomas R. Gnau, radiology (radiopharmacy); Dr. Richard E. Hall, physiology; and Dr. Frederick Kremkau, medicine (research).

Dr. J. Edward Holl was promoted to assistant professor in the medical school's Division of Allied Health Programs.

J. Patrick Kelly, former executive news editor of the *Winston-Salem Journal* and *Twin City Sentinel*, has been appointed director of development for the Bowman Gray School of Medicine and North Carolina Baptist Hospital.

The appointment was effective June 10.

Kelly's responsibilities include supporting the Medical Center's fund raising activities, particularly as they relate to the private sector. He also will be involved in long-range planning for the Medical Center and will provide administrative support in the further development of alumni affairs.

Kelly is a graduate of the University of North Carolina at Chapel Hill and studied as a Nieman Fellow at Harvard University.

* * *

Twelve students have been installed as new members of Alpha Omega Alpha, national medical honor society.

Election to AOA is based on scholastic achievement and character.

Senior students elected to AOA include Joseph J. Dobner of Melrose Park, Ill.; John S. Kelley of Whiteville; Edward F. Haponik of Fall River, Mass.; William R. Lambeth of Greensboro; Richard Marx of Wheaton, Ill.; Joel B. Miller of Statesville; James D. Rogers of Big Rapids, Mich.; James S. Strohecker of Columbia, S. C.; and Bruce D. Waller of New Castle, Del.

Elected from the junior class were Michael C. Scruggs of Henrietta, James D. Sink of Lexington, and Edwin H. Shoaf of Charlotte.

* * *

The Department of Neurology has received a \$10,000 grant to support research into myasthenia gravis and related neuromuscular disorders.

The grant was made to the department's Welch-Kempton Myasthenia Gravis Research Fund by Miss Mary E. Welch of Horse Shoe, N. C.

The grant will support the Welch-Kempton Myasthenia Gravis Research Award, given each year to a medical student for a research project. The award carries a \$150 prize and a plaque.

* * *

The medical school has received a \$53,199 grant from the National Fund for Medical Education to develop a new audiovisual self-instructional course in radiographic anatomy.

Dr. Joseph E. Whitley, professor of radiology at Bowman Gray, will work with Dr. I. Meschan, professor and chairman of the Department of Radiology at Bowman Gray, and Dr. Lucy Frank Squire, professor of radiology at the Downstate Medical Center in Brooklyn of the State University of New York.

The research project is a cooperative effort between Bowman Gray and the Downstate Medical Center.

The grant is intended to provide more efficient teaching methods to allow the future physician to

what he must know to give the best possible
While the new course will be developed primarily
freshman anatomy students, it may also be used
advanced medical students, interns, and residents
would like to review the material.

A prototype of the program is planned to be ready
fall for use in teaching freshman anatomy stu-
ents here and in Brooklyn.

* * *

Dr. Robert A. Diseker, assistant professor of com-
munity medicine, has been appointed to the board
of directors of the North Carolina Health Council.
He will serve as chairman of the council's Health
Education Committee.

* * *

Dr. Robert Dixon, assistant professor of radiology,
has been elected president of the Southeastern Chap-
ter of the American Association of Physicists in
Medicine. He has also been appointed to the Scien-
tific Committee of that organization.

* * *

Dr. Richard Janeway, dean of the medical school,
has been appointed to the National Advisory Coun-
cil on Regional Medical Programs of the Health
Resources Administration.

The appointment was made by Casper Weinberger,
Secretary of Health, Education, and Welfare. The
Council advises and assists the Secretary in the pre-
paration of regulations for the policy matters con-
cerning the regional medical programs.

* * *

Dr. Joseph E. Whitley, professor of radiology, has
been elected to a Fellowship in the American College
of Radiology. He has been elected to the Board
of directors of the James Picker Foundation of White
Plains, N. Y. The foundation was established with
the purpose of fostering research in radiology.

News Notes from the—

UNIVERSITY OF NORTH CAROLINA DIVISION OF HEALTH AFFAIRS

Five persons were honored in Chapel Hill in
March when the UNC School of Medicine gave them
its highest honor, the Distinguished Service Award.
They are: Dr. Nathan A. Womack, first chairman
of the Department of Surgery at the UNC School
of Medicine; Mrs. Martha Love Ayers, a Greensboro
philanthropist; Dr. Sarah T. Morrow, director of the
Guilford County Health Department, through which
she started the nationally recognized Comprehensive
Children and Youth Project; Dr. George Denman
Jr., a nationally known pediatric malignant
disease specialist and associate dean, University of

Southern California; and Dr. Corbett L. Quinn, a
family practitioner in Magnolia.

* * *

Crohn's Disease which has no known cause and
which can mock any disorder affecting the abdominal
organs, including appendicitis, is being examined at
UNC-Chapel Hill.

UNC physicians headed by Dr. John T. Sessions,
chief, Division of Gastroenterology, will study the
effects on patients of the three most commonly pre-
scribed medications.

Officially, this three-year program is called the
National Crohn's Cooperative Study and is funded
by the National Institute of Arthritis, Metabolism and
Digestive Diseases.

* * *

Fred M. Eckel, director of pharmacy services for
North Carolina Memorial Hospital, and associate
professor in the UNC School of Pharmacy, has been
named 1973 Hospital Pharmacist of the Year by the
North Carolina Society of Hospital Pharmacists. The
award was presented by the Pfizer and Roerig Divi-
sion of Pfizer Laboratories in New York.

* * *

Dr. Larry J. Leoffler, assistant professor of medi-
cinal chemistry at the UNC School of Pharmacy in
Chapel Hill, has received a \$27,820 research grant
from Sandoz Pharmaceuticals of Hanover, New Jer-
sey.

The grant will support research in the development
of methods potentially useful for measuring very
small quantities of ergot alkaloids which are found in
biological fluids, such as plasma or urine. These com-
pounds are part of drugs used in the treatment of
ailments such as migraine headache and excessive
bleeding.

* * *

The UNC Department of Nutrition in Chapel Hill
has been tapped to conduct a nationwide medical
evaluation of the \$40 million federal food and nu-
trition program for women, infants, and children.

Dr. Joseph Edozien, chairman of the Department,
said the bulk of the \$40 million from the U.S. De-
partment of Agriculture will go into food for preg-
nant women, nursing mothers, infants, and children.

The UNC nutritionist and his staff will conduct
medical evaluation studies in 15 states, from Califor-
nia to New York and from Minnesota to Texas.
North and South Carolina are included in the project.

* * *

Students at North Carolina Central University in
Durham will have an opportunity next year to major
in health administration in the school's Department
of Business Administration.

The new program will be made possible through
a cooperative arrangement with the UNC School of
Public Health's Department of Health Administration
in Chapel Hill.

John V. Turner of NCCU and Dr. Patricia Barry
of UNC are serving coordinators of the curriculum

development committee. Turner is chairman of NCCU's Department of Business Administration. Dr. Barry is a professor of health administration at UNC.

* * *

The first joint meeting of British and American physicians to be held in the United States was held April 8-9 at UNC-Chapel Hill.

The three-day Anglo-American conference on Continuing Medical Education was sponsored by the Royal Society of Medicine in London, the Royal Society of Medicine Foundation in New York, and the UNC School of Medicine.

The conference brought authorities from both sides of the Atlantic to discuss how physicians can learn new skills and information to improve patient care.

* * *

A dedication service for the Louis G. Welt Fellowship in the Department of Medicine at the UNC School of Medicine in Chapel Hill was held March 30 on the UNC campus.

Dr. Robert L. Ney, professor and chairman, Department of Medicine, announced the establishment of the fellowship in honor of the late Dr. Welt who died earlier this year.

Dr. Welt joined the UNC faculty in 1952 and was named chairman of the Department of Medicine in 1965. He served in that chair until 1972 when he went to Yale University.

* * *

Robert Wilson of the Carolina Population Center at UNC-Chapel Hill has edited a guide to problem pregnancy and abortion counseling. The 120-page resource book contains up-to-date information for counselors on the general principles of problem pregnancy counseling. Chapters examine alternatives in continuing a pregnancy, the abortion alternative including medical and legal information, promoting responsible sexual behavior, responsibilities in contraceptive counseling, and contraceptive and reproductive education.

This book came from the first North Carolina Workshop on Problem Pregnancy Counseling, attended by more than 500 counselors from nearly all of North Carolina's 100 counties.

News Notes from the—

DUKE UNIVERSITY MEDICAL CENTER

Two School of Medicine faculty members have been named to James B. Duke Professorships, the highest academic honor the university bestows on its distinguished teachers.

They are Dr. Robert L. Hill, professor and chairman of the Department of Biochemistry, and Dr.

NEW! Patient Therapy Packs

Because many patients tend to stop treatment prematurely, the full course of b.i.d. therapy is now specially packaged to encourage patients to complete the full course of therapy.

CANDEPTIN Vaginal Ointment Therapy Pack—two 75 gm. tubes

CANDEPTIN Vaguettes

Therapy Pack—28 vaginal capsules

CANDEPTIN Vaginal Tablet

Therapy Pack—28 vaginal tablets

Brief Summary

Description: CANDEPTIN (Candidin) Vaginal Ointment contains a dispersion of Candidin powder equivalent to 0.6 mg. per gm. or 0.06% Candidin activity in U.S.P. petrolatum. 3 mg. of Candidin is contained in 5 gm. of ointment or one applicatorful. CANDEPTIN Vaginal Tablets contain Candidin powder equivalent to 3 mg. (0.3%) Candidin activity dispersed in starch, lactose and magnesium stearate.

CANDEPTIN VAGUETTES Vaginal Capsules contain 3 mg. of Candidin activity dispersed in 5 gm. U.S.P. petrolatum.

Action: CANDEPTIN Vaginal Ointment, Vaginal Tablets, and VAGUETTES Vaginal Capsules possess anti-microbial activity.

Indications: Vaginitis due to *Candida albicans* and other *Candida* species.

Contraindications: Contraindicated for patients known to be sensitive to any of its components. During pregnancy manual Tablet or VAGUETTES Capsule insertion may be preferred since the use of the ointment applicator or tablet inserter may be contraindicated.

Caution: During treatment it is recommended that the patient refrain from sexual intercourse or the husband wear a condom to avoid re-infection.

Adverse Reaction: Clinical reports of sensitization or temporary irritation with CANDEPTIN Vaginal Ointment, Vaginal Tablets or VAGUETTES Vaginal Capsules have been extremely rare.

Dosage: One vaginal applicatorful of CANDEPTIN Ointment or one Vaginal Tablet or one VAGUETTES Vaginal Capsule is inserted high in the vagina twice a day, in the morning and at bedtime, for 14 days. Treatment may be repeated if symptoms persist or reappear.

Available Dosage Forms: CANDEPTIN Vaginal Ointment is supplied in a Patient Therapy Pack, containing two 75 gm. tubes with two applicators for the full course of treatment. CANDEPTIN Vaginal Tablets are packaged in boxes of 28, in foil with inserter—enough for a full course of treatment. CANDEPTIN Vaguettes Vaginal Capsules are packaged in a Patient Therapy Pack, containing 28 CANDEPTIN Vaguettes Vaginal Capsules (2 boxes of 14), for the full course of treatment. Store under refrigeration to insure full potency.

Federal law prohibits dispensing without prescription.

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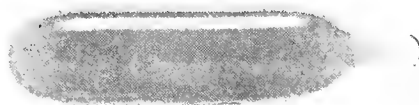
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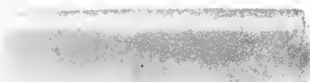
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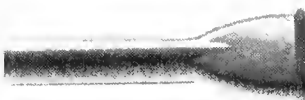
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Hill is a specialist in protein and enzyme chemistry. A graduate of the University of Kansas, he came to Duke in 1961 from the University of Utah. He has headed the department since 1969.

Odom is a graduate of the Tulane University Medical School and has been at Duke since 1943. Odom has headed the neurosurgical division since 1960.

* * *

Dr. Andrew G. Wallace, a professor of medicine and chief of the Division of Cardiology, has been named to the newly established Walter Kempner Professorship.

Kempner, a member of the Duke faculty for 38 years, is widely known as creator of Duke's "rice diet" program.

Kempner was brought to Duke by Dr. Frederic Hanes, who first met him while in Berlin visiting Dr. Otto Warburg, the Nobel laureate in biochemistry. Kempner came from a distinguished background, both of his parents having held professorships in medical schools in Germany. Warburg regarded Kempner as a man of extraordinary promise.

Eager to add a full-time medical investigator of outstanding competence to the Department of Medicine he then headed, Hanes offered Kempner an

appointment which he eventually accepted, becoming the first salaried member of the Department of Medicine whose major responsibility was medical research. He remained on the faculty at Duke until his retirement in August, 1972. He is now serving in a consultant capacity to the medical center.

The professorship established in his name has a twofold purpose—to honor Kempner by the appointment of an outstanding clinician-investigator to an endowed professorship, and to encourage additional support for the continuation of Kempner's special interests, notably the program of research in cardiovascular and nutritional diseases. In this way the Department of Medicine hopes to recognize in small part the contributions Kempner has made to his patients, to his field, and to Duke University Medical Center.

Wallace graduated from the Duke Medical School in 1959. He was appointed to the Duke faculty in 1964, and in 1967 he was named director of the Myocardial Infarction Research Unit. Wallace, who also holds an appointment as assistant professor of physiology, became chief of cardiology in 1970 and was promoted to full professor the following year.

* * *

Genie Kleinerman, a third-year medical student, presented a paper on "Depression of Monocyte Chemotaxis by Virus" at a meeting of the Federal

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* * *

With what is believed to be one of the largest
gifts donated by a hospital auxiliary at one time, the
Duke Hospital Auxiliary has pledged \$100,000 over
the next four years to the building fund of the new
Duke Hospital North."

The Duke expansion project is expected to cost
approximately \$90 million. Dr. William G. Anlyan,
vice president for health affairs, said the auxiliary's
pledge will be applied to the more than \$30 million
Duke needs as equity on which to borrow the remain-
ing funds for construction.

* * *

Dr. W. Gerald Austen, professor of surgery at
Harvard and chief of the surgical services at the
Massachusetts General Hospital, delivered the 12th
annual Deryl Hart Lecture in April.

His topic was "Surgical Treatment of Acute Coro-
nary Artery Disease."

The lecture honors Dr. Deryl Hart, former chair-
man of surgery and president-emeritus of Duke Uni-
versity.

AIR FORCE RECRUITING DETACHMENT 307

Eight North Carolina medical students have been
awarded Armed Forces Health Professions Scholar-
ships, including commissions as Air Force Reserve
second lieutenants, through the work of the Air Force
medical recruiting team in Raleigh.

Harold A. Nichols, UNC School of Medicine, was
the first medical student in the nation to be commis-
sioned under the program. Others are: from UNC
School of Medicine—Gwendolyn M. Boyd, Herman
Mady Morgan, Jr., Scott H. Norwood, and Uiril C.
Keene; from Bowman Gray School of Medicine—

Michael C. Scruggs and William S. Browner; from
Duke University School of Medicine—Jeffrey B.
Symmonds.

The scholarship includes tuition, books, equip-
ment, fees, and \$400 monthly during the student's
pursuit of an M.D. degree. Upon graduation, the
student may enter active duty (a commitment of one
year for each scholarship year), or, if selected, he
may pursue post-graduate medical education at a
civilian institution.

For information regarding graduate medical edu-
cation programs (residencies and fellowships) avail-
able to active duty medical professionals on a com-
petitive basis, Captain Glenn T. Satterfield, MSC,
USAF, and Technical Sergeant James C. Dotson of
the Air Force medical recruiting team are available
to meet with those interested in the program at the
Federal Building, 310 New Bern Ave., Room 333,
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ful to the patient who changes physicians.

Month in Washington

Triggered by the surprise introduction of a Ken-
edy-Mills proposal for national health insurance and
a major effort by the Nixon Administration to get its
bill through this year, the Congress has again
fostered a hot and heavy debate on the complex issues
involved.

Appearing before the House Ways and Means
Committee, Russell B. Roth, M.D., president of the
American Medical Association, warned that most of

the Congressional push for national health insurance
(NHI) is based on the false premise that there is a
health care crisis.

"The fact is," Dr. Roth told the Committee, "more
people are receiving more and better medical care
from more and better trained physicians in more and
better equipped facilities than ever before in history.
These are not elements of crisis. The fact also is that
the public, as its opinion has been judged in various

polls, does not perceive medical service to be a major problem area.

"No doubt the Committee recalls a recent Louis Harris poll, commissioned by a Senate subcommittee, which indicated that, whereas 64 percent of the sample identified inflation as our nation's most serious problem, health care rated 15th, or next to last on the list, with only three percent of the respondents putting emphasis on this. Inasmuch as any of the proposals for extensions of federal subsidies for medical service are inevitably inflationary to some degree, one wonders about the advisability of further aggravating this most serious problem in order to attack a problem of much lesser magnitude.

"Poll after poll confirms that people are generally satisfied with the type of health care they personally receive. This satisfaction relies on wide experience, for some 2.5 million people a day see a physician. A 1971 University of Chicago study, based on a nationwide sample, found 84 percent of the people satisfied and only ten percent dissatisfied. Just last month, a survey commissioned by the *Washington Post* uncovered a virtually identical pattern in this

area. According to Mr. Jay Mathews' story, six of every seven local residents are at least 'pretty satisfied' with their medical care. Only one person in ten expressed any measure of discontent. It would be an interesting exercise to see if you could find another issue or subject these days upon which Americans would voice 85 or 90 percent agreement.

"Reflected in the results of the polls is a record of at least ten years of substantial progress. During this period, the number of American medical schools and the number of physicians available to the American public have been increasing. The number of physicians will continue to increase at a pace which exceeds the general population growth rate."

Speaking strongly in support of the AMA sponsored Medicare bill for NHI, Dr. Roth urged the Committee to follow the guiding principles developed by the AMA in its proposed legislation.

"We are convinced," Dr. Roth said, "that financial barriers to medical services are as real for middle income persons as for the poor—that there is great virtue in attention to ability to pay deductible and coinsurance amounts—and that our graded tax-cred-



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approach is a superior feature in adjusting subsidies needs."

Lashing out at the Kennedy-Mills NHI proposal, Roth said, "It is one thing to mandate the purchase of private insurance by employers. It is something quite different to institute increased payroll taxes, destroy the future of private insurance, and shift a well-regarded private function into a federal agency."

"The financing envisioned in the Kennedy-Mills proposal gives us several problems:

"It creates a massive four percent increase in the Social Security tax. Wage earners will not be deterred by the fact that three percent is to be paid by employers and one percent by employees. The public is sophisticated enough to know that there is no free ride in this respect and that the source of the funds to pay for such federal programs is from their contribution."

"We would point out further that under Social Security taxes, he who earns \$20,000 a year pays the same as the person who earns \$90,000 or \$100,000. In our view, it would be more equitable for those who make more to pay more. We would prefer the sort of consistent sliding scale approach that is embodied in the Medicare bill. Finally, we would seriously question the proposition that, by eliminating the profit factor, Social Security handling of health insurance finances will bring economies and efficiencies."

"The track record of government—our own and others as well—provides scant historical evidence of the government's capacity to manage surpasses private management in terms of either efficiency or economy."

"Administrative control derives in large part from financing mechanisms, and, since we advise strongly against control of a new program by the Social Security Administration, we would avoid Social Security financing."

"There can be no justification for the establishment of a vast and expensive new corps of clerks and bureaucrats, dedicated to the task of complicating what should be a relatively simple program for placing in the hands of the eligible beneficiary a policy of insurance or a contract for service tailored to his needs."

* * *

The day before the AMA testimony before the Ways and Means Committee, Health, Education, and Welfare Secretary Caspar Weinberger told committee members that the Administration is dead serious about pushing for enactment of an NHI program this year.

Secretary Weinberger came down hard on the Kennedy-Mills proposal that would move toward the nationalization of the nation's health care.

Discussing the "fundamental differences" between the so-called compromise plan sponsored by Kennedy and Mills, and the Administration's Comprehensive

Health Insurance Plan (CHIP), Weinberger declared:

"I would be less than candid if I did not stress how strongly we are committed to the basic principles of the CHIP proposal."

The Secretary told the crowded hearing room that "the national climate has never been more favorable for the development of a sound consensus on a national program of health insurance. . . . I am here to urge—just as strongly as I possibly can, personally and on behalf of the Administration—that this clear chance at solid accomplishment not pass without the nation's action."

"We firmly reject the views of those few who counsel that no action be taken until some vague, future time when, they believe, their own plan can be enacted. Such a time will never arrive."

A major reason for prompt action, Weinberger said, is the prospect that "the American people appear to be in for a very rough period indeed as far as health care costs are concerned." Congress' failure to approve continued wage-price controls on health care could lead to a \$4-5 billion increase in health care costs next fiscal year and \$9 billion the following year, he cautioned.

If this happens, all current cost estimates for various NHI proposals "would be far too low." He said "the nation desperately needs measures to avoid such a pocketbook disaster."

In devising the CHIP plan, based on mandated employer health insurance plans for employees, Weinberger said the Administration believed "it is imperative to improve, rather than demolish, the present system."

Although the cabinet Secretary took swipes at all the major NHI competitors to CHIP, he not surprisingly reserved most of his fire for the Mills-Kennedy compromise. This bill calls for a Social Security NHI financed by a four percent tax and administered by Social Security as a virtually independent agency.

Mills-Kennedy, according to Weinberger, "would take a major step down the road toward complete federal financing and control of all health care in the United States. If that policy approach were to prevail, I feel there would be no turning back."

The financing of health care is too important to the people "to turn over to a federal bureaucracy," he asserted. Noting the complexities of the health system and the relative lack of knowledge of its workings, he said, "in these circumstances the dangers of turning financial control of this vital industry over to an enormous new federal bureaucracy are considerable."

Quashing speculation that the Administration might try to reach an accommodation on the Mills-Kennedy approach, Weinberger hammered away at it, making it plain that he regarded the Mills-Kennedy plan as the big danger. He said it would stifle private

initiative "under piles of paperwork and federal regulations."

"We believe that the federal role in health financing must be clearly limited, as it is in CHIP. National health insurance should not be the nationalization of the health system," he continued.

The Administration officer said Mills-Kennedy would impose \$40 billion of new federal taxes "on top of a tax burden that many Americans already believe is excessive." Furthermore, Weinberger said, "payroll taxes are a much greater burden on the poor than is general revenue financing."

He said the Kennedy-Mills plan would virtually eliminate privately administered health insurance and substitute a fully federally financed and administered system. "Our present system should be improved upon rather than dismantled in favor of a costly, inflexible federal system," he said.

"The budgetary impact on the federal government," Weinberger maintained, "is simply unacceptable."

* * *

The government's procedures to assure that Professional Standards Review Organizations (PSROs) represent physicians in their local areas have been announced.

The PSRO law requires that the HEW department, before entering into an agreement with an organization to be the PSRO for an area, must notify the physicians of that area of the intent. The physicians then have the opportunity to object to a specific or-

ganization's being named as the PSRO. The method to be used in notifying the nation's physicians of proposed PSROs, and the subsequent steps to be taken in assuring that the organizations are acceptable to the physicians, are detailed in the *Federal Register* of April 16.

"In keeping with the PSRO legislation, we have developed procedures to assure that the organizations established as PSROs throughout the country are truly representative of the physicians in each of the PSRO areas," HEW Secretary Caspar Weinberger said. "It is the local physicians who will plan, operate and control the PSRO in each area, and, therefore, the organization designated as the PSRO must be their organization," he said.

When the Secretary has determined that a local physician organization is qualified to perform the PSRO functions required by law, he will notify the area's physicians and other health professionals of the announcement in the local press and mailed notice to physician and hospital organizations active in the area. The notice will also be published nationally in the *Federal Register*.

The notice will announce the Secretary's intention to enter into a financial agreement with a specific organization, describe the organization, and indicate that active, practicing physicians in the area have 30 days in which to protest the proposed selection. If less than ten percent of the local area's physicians object to the proposed organization, the law provides

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that the Secretary can designate and fund the PSRO that he has chosen. However, if more than ten percent do object, the Secretary will conduct polls of the physicians in the area. To each physician who practices in the area, HEW will mail a ballot on which he can indicate whether the organization provisionally selected by the Secretary does or does not represent him.

A 30-day period will be allowed for the ballots to be returned. If more than 50 percent of the respondents to the poll indicate that the organization does not represent them, the Secretary will no longer consider that organization for PSRO designation. If less than half object, the Secretary, by law, can conclude his agreement with the local PSRO.

* * *

The government has labeled as "factually inaccurate and misleading" a kit on Professional Standards Review Organizations (PSROs) prepared by the American Medical Association.

In a critique of the kit, the Health, Education and Welfare Department said many of the PSRO review functions actually are embodied in the Social Security Act's Medicare and Medicaid provisions that were approved long before PSRO.

The HEW paper contends that the purpose of PSRO "was to give practicing physicians priority in undertaking the review of care provided, rather than have the review performed by those outside the medical profession."

Contents of the kit, entitled "PSRO—DELETE-

RIOUS EFFECTS," have been criticized by HEW and Senator Wallace Bennett (R., Utah), chief Congressional sponsor of the PSRO provision. The kit was prepared and distributed by the AMA at the behest of the AMA's House of Delegates to alert the medical profession to the dangers of such a review system.

* * *

Theodore Cooper, M.D., has been appointed deputy to Assistant HEW Secretary for Health Charles Edwards, M.D. Dr. Cooper is director of the National Heart and Lung Institute. Henry Simmons, M.D., who has been serving as Dr. Edwards' right-hand-man, will continue to hold a deputy position, but will concentrate henceforth most of his efforts at directing the Professional Standards Review Organization (PSRO) program. Dr. Cooper is regarded as one of the government's most capable health officers. One of the first heart transplant researchers, he is a renowned expert on the heart.

* * *

John Chase, M.D., a Veterans Administration career medical official for 22 years, has been appointed Chief VA Medical Director. VA Administrator, Donald Johnson, also announced the appointment of Dr. Laurance Foye, Jr., M.D., as Deputy Chief Medical Director of the agency. Dr. Chase succeeds Marc Musser, M.D., who resigned. Foye replaces Benjamin Wells, M.D., who retired last January 23.

Book Reviews

Faith Healing: Finger of God or Scientific Curiosity?
Compiled by Claude A. Frazier, M.D. 192 pages. Price, \$5.95. New York and Nashville: Thomas Nelson, Inc., 1973.

Claude A. Frazier was taught by his mother that he was healed by divine intervention when he was seriously ill as a child. He learned that prayer helped bring healing to his own son. As an active layman of the church Dr. Frazier was asked by ministers, "What do you think of faith healing?" This book, says Frazier, "is an attempt to answer this question" (p. 9). Frazier shares twenty responses by other physicians, rather than answering the question himself. He gives no criteria by which he selected the essays, nor does he organize them in any topical or developmental sequence.

Some of these essays preclude that faith healing could not be experienced by a person who is not of the Christian faith. A few of the chapters are overly simple in their approach to faith healing that they become superficial. Omitting some chapters would have strengthened the quality of the book and would have done away with extensive duplication. Some of the writers come across as Biblical interpreters rather than physicians, and in some cases the Biblical scholarship is very limited.

The subject addressed in this book is timely. It does not give the reader the comprehensive historical foundation for faith healing that one finds in a book like *Healing and Christianity* by Morton Kelsey (Harper and Row, 1973; 398 pp., \$8.95).

The strength of Frazier's book is in the quality of

new good essays, which makes me pleased to have this book in my library.

Many of these essays communicate the thesis that healthy spirit is essential to a healthy mind and body, and that faith has transformed the lives of many hopeless and dying people.

The last chapter, "From Epidauros to Lourdes: A History of Healing by Faith," by David H. L. Robertson, gives an overview of faith healing as practiced in non-Western cultures, in Judaism, in the Christian Church, and modern day religions, including the development and use of relics. This chapter is useful background for reading or viewing *The Exorcist*. Robertson declares that in all of the exercises of faith healing, and in some cases, demonstrations, "no one will ever know how much of the cure depends on the patient's desire and expectation that he be healed. But most physicians recognize that motivation is a powerful force aiding recovery. In spite of this, there are surely few in the field of medicine who have not, on some rare occasions at least, witnessed a recovery so unexpected, so contrary to the usual prognosis, and so apparently complete, that the word 'miracle' seemed the only appropriate description of it" (p. 388f.).

"The Personal Meaning of Faith Healing" by F. Mansell Pattison discusses the use of the MMPI as an instrument in studying persons who have experienced faith healing. The author says that these persons are characterized by a high degree of denial and repression of disturbing emotions, and an exaggerated need for social acceptance. Dr. Pattison says these subjects participate in faith healing as a means of rectifying their perception of being in a sinful state in their relationships to God . . . the faith healing experience reinforces to the person the value, importance and certainty of rightness of their religious style of life" (p. 113).

As a hospital chaplain, I found the essay "The Nights Hospitallers" by Bernard J. Ficarra an intriguing chapter, tracing the history of hospitals through religious Crusaders. I was especially interested in this subject, in light of the recent establishment of hospices in both Europe and the United States.

Several chapters speak of the need for the physician to utilize his faith in treating patients. Health and healing is a medical-faith-personality dynamic of both the patient and the physician.

"Death, Dying and Cancer—Implications for the Christian Physician," by Donald M. Hayes, is, in my opinion, the best written of the twenty essays. Hayes points out the limitations of the physician in treating the cancer patient. The physician is caught

in the dilemma of the Hippocratic Oath, between "to relieve suffering" and "to prolong and protect life." Hayes has no evidence of ever having seen faith healing occur, yet he says "I have seen remarkable instances of improvement or disappearance of cancer. . . which are explainable on the basis of immunology of the patient rather than some bizarre metaphysical abridgment of natural law" (p. 145).

For the physician or chaplain who takes seriously his role to bring about healing in the lives of people, this book raises important questions which no professional person can afford to put aside lightly.

EARL A. HACKETT, S.T.M.

Review of Physiological Chemistry. By Harold A. Harper, Ph.D. 545 pages. 14th edition. Los Altos, California: Lange Medical Publications, 1973.

The title of this book renders it a small disservice, since it implies that the reader should have some prior knowledge of the subject in order to use the volume. Such is not the case, as thousands of medical students who use it as a primary textbook can attest. This volume, first published in 1939, has at least three characteristics which render it highly useful: it is concise, and yet reasonably complete; it is more medically oriented than the standard textbooks of biochemistry; and it is updated every two years.

The 14th edition has just been released and it carries on the tradition of its predecessors. Once again, the author has resisted the temptation to turn this volume into a compendium, so that this edition has increased in size by only 16 pages. Most of the chapters have been retained virtually intact; the new material largely emphasizes recent advances in medically related topics. A short, but much needed, section on erythrocyte metabolism has been included, and the section on solubilization of cholesterol in the bile has been expanded to reflect recent interest in this area. The pages devoted to disorders of amino acid metabolism have been thoroughly revised and updated. The description of these disorders is the best I have encountered in a biochemistry textbook.

But perhaps the best chapter of the book is that dealing with hormone activity. Chapter 20 is the best single introduction to the biochemistry of hormones currently available. This material has been updated to include information on recent topics, such as the mechanism of action of glucocorticoids and interrelationships between c-AMP and calcium ion.

If you already own the 13th edition of this book, the changes are probably not sufficient to make it outdated; if you do not, the 14th edition is well worth the small investment.

LAWRENCE DECHATELET, Ph.D.

In Memoriam

Shankar Nath Kapoor, M.D.

Dr. Shankar Nath Kapoor died at Watts Hospital in Durham, North Carolina on December 23, 1973 at the age of 42 years. He was born on September 15, 1931 in Lucknow, India.

Dr. Kapoor received his M.D. degree from King George's Medical College in 1953. From 1955 to 1957 he served a surgical residence at Nashville General Hospital. From 1957 to 1961 he received his residency training in orthopedics with the Duke Medical Center affiliated training program. He entered the private practice of orthopedic surgery in Durham on July 1, 1961. He was on the staffs of Watts Hospital, Lincoln Hospital, and the Veterans Administration, and he served as an Assistant Clinical Professor of Orthopedic Surgery at Duke University Medical Center.

He was a member of the American Medical Association, Durham-Orange County Medical Society, Southern Medical Association, North Carolina Medical Society, Piedmont Orthopedic Society, and Fellow of the American Academy of Orthopedic Surgery.

Dr. Kapoor was held in the highest esteem by his colleagues and patients. He was widely respected as a teacher and practitioner of orthopedic surgery, and his untimely parting will be felt by all who knew him.

Surviving are his wife, Mrs. Nancy Nelms Kapoor, two sons, Kristopher of the home and Karl of Durham, and a daughter, Miss Pam Kapoor. He is also survived by several brothers in India.

DURHAM-ORANGE COUNTIES MEDICAL SOCIETY

Dan Parker Boyette, Jr., M.D.

WHEREAS, we, his medical colleagues, are sorely grieved by the unexpected death of our friend and fellow physician on March 1, 1974, and

WHEREAS, we are fully cognizant of his diligent and devoted service to the children of the Roanoke-Chowan area and beyond over a generation of time and

WHEREAS, we recall with pride his preparation for medicine and his selected speciality, his service in the Army of the United States, his contributions to the pediatric literature, his role of leadership in organized medicine, and his accomplishments in promoting excellence in the field of pediatrics, and

WHEREAS, this outstanding gentleman gave freely of his available time and energy to the betterment of this community, as an inspiring leader and enlightened citizen through his fond association with the First Baptist Church, Kiwanis International, the Ahoskie District School Committee, the Social Services Board of Hertford County, and other organizations, and

WHEREAS, we respect and admire his example as a devoted husband, father, and son, and will truly miss him as a friend, be it therefore

Resolved, that the above statements, revealing our fondness and respect for our departed friend, be incorporated into the permanent minutes of the Hertford County Medical Society and of the Medical Staff of the Roanoke-Chowan Hospital, and furthermore, that copies be sent to his bereaved family and to the official Journal of the North Carolina Medical Society.

HERTFORD COUNTY MEDICAL SOCIETY

The basis of juleps is generally common water, or some simple distilled water, with one-third or one-fourth its quantity of distilled spirituous water, and as much sugar or syrup as is sufficient to render the mixture agreeable. This is sharpened with vegetable or mineral acids, or impregnated with other medicines suitable to the intention.—*William Buchan: Domestic Medicine, or a Treatise on the Prevention and Cure of Diseases by Regimen and Simple Medicines, etc., Richard Folwell, 1799, p. 453.*

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July 1974, Vol. 35, No. 7

NORTH CAROLINA

Medical Journal

THIS ISSUE: The President's Address: Where We Stand, George G. Gilbert, M.D.; Message of the President to the House of Delegates, George G. Gilbert, M.D.; Control of Diseases Preventable by Active Immunization in North Carolina—Past, Present, and Future, J. N. MacCormack, M.D., M.P.H., and Jacob Koomen, M.D., M.P.H.; Carpal Desmotomy: Technical Note, Timir Banerjee, M.D., and John N. Meagher, M.D.



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The President's Address Where We Stand

George G. Gilbert, M.D.

TWO years ago, I assumed the duties as your President-elect, with the utmost humility, and still feel the same way. On the one hand, the experience has been most rewarding and inspiring so that it will be a landmark the rest of my life. On the other hand, I have much the same feelings as a previous president of the California Medical Society who wrote in the *AMA News* that he surely would not want to tackle it for another year.

For fear of omitting some of the names of the many people who have greatly contributed to this Society, in my remarks to the House of Delegates I expressed my thanks in general. Now, however, I want to pay tribute to two of our members, both of whom have been invaluable to me with their help, and once again this does not exclude the many others who have made outstanding contributions. I refer to Dr. John Glasson, my predecessor, whose wisdom and experience have taught me so much, and equally to Dr. Frank Reynolds, your past President, who has been of inestimable help as President-elect.

Prior to my assuming office, it was mentioned to me by Mr. William Hilliard, our Executive Director, that each president had a central theme for his administration. For the life of me, I must say that the extreme variety of the demands of the office have left me without any such central theme. The primary activity has been a matter of acting and reacting to many rapidly changing situations, so that it catches one's breath. Coping with the crises and the mundane duties, day in and day out, has left little

time for innovations, although I do hope that I have been responsible for a few.

As my predecessors, I too have turned to past presidential addresses for guidance and inspiration. As Dr. Styron mentioned in his 1972 message to the House of Delegates, there has been a common thread weaving its way, with varying emphasis, through all of the presidents' administrations, throughout each year. However, for the most part, the challenge has involved the experiences and problems that are with us year in and year out, along with some new ones. In fact, my predecessors have so well expressed the fundamentals we believe in, that I have the temptation to say "me too" and sit down, with just the recommendation that you read what they have had to say.

I agree with them, however, that at least a list of these common threads, with comments on some and a look into the hectic future, seem to be a logical approach to bring you up-to-date as to where we stand with our State Medical Society.

COMMUNICATIONS

One of the major threads that have been mentioned and are forever a basic requirement for success in any society, as well as in our lives individually, is constantly improving communications. I was told by Mr. Hilliard that he thought the *President's Newsletter*, initiated by Dr. Louis Shaffner, was the best communications medium the State Society had with its members, and that the *Newsletter* was probably read by more members than any other avenue of communication. My experience confirms this view, and I want to take this opportunity for thanking a great many of you for expressing your apprecia-

Read before the Second General Session, North Carolina Medical Society, Pinehurst, May 21, 1974.
Print requests to Dr. Gilbert, 1 Doctor's Park, Asheville, N. C.

tion of these monthly newsletters. I certainly recommend that my successors continue them.

HEADQUARTERS STAFF

Each of my predecessors has expressed praise for our Headquarters staff. It has been a hectic year for them, with lots and lots of long hours, over and above the call of duty, by all concerned. As you well know, the increasing load of work in setting up and cooperating with our new North Carolina Medical Peer Review Foundation, Inc., took more and more of Mr. Dan Mainer's time. The increased responsibility led ultimately to his officially leaving the Medical Society Headquarters staff to become Executive Director of the Peer Review Foundation. This, of course, left a gap and placed additional burdens on not only Mr. Hilliard, but LaRue King, Steve Morrisette, and Gene Sauls. Furthermore, with our crises, both in politics and legislation, it was recommended to the Executive Council that we have a full-time staff person for legislative and MEDPAC activities. Steve Morrisette has, of course, been the logical person for this position and has done a yeoman's job. With this recent reshuffling of our Headquarters staff, this area will be his primary sphere of interest. The rest of the staff have had their titles modified and their salaries have been raised, but believe me, not nearly as much as they deserve. We are getting a bargain with our wonderful staff. Because the work of our staff members is essential (and we are still short at least one staff person), should it become necessary budgetary-wise, I would not hesitate to recommend increasing our dues, onerous as that is to everybody.

STATE AND NATIONAL LEGISLATION

In my inaugural address a year ago, I stated that the primary crisis facing the State Medical Society, and medicine in general, was PSRO, and I believe the experience of this past year has borne me out. Our *Newsletter* and the *AMA News* substantiate that there has been a tremendous turmoil in this area of activity. My own summary as to the cause of the increasing rebellion regarding this law is that all of us who tried, in our various state and county societies, to tool up for the PSRO effort, became increasingly thwarted and discouraged by not having our recommendations taken. This is probably an oversimplification, but look at it from this point of view. I believe that if, from the beginning, the PSRO office in Washington had listened to their own Advisory Council (and they did not on many occasions), and secondly, if they had gone along with all the various states' recommendations, as far as the geographic boundaries were concerned, rather than setting up their own capricious guidelines, there could be much more harmony on the PSRO front than there is today. Most recently, Dr. Russell Roth, President of the AMA, and our own Ed Bedding-

field gave testimony before a committee in Congress on this very subject, and they have reflected in great detail our concerns on the national level.

From all indications, I believe that one of our goals has been achieved to some degree, and that the average physician does know what PSRO is all about. Despite the fact that we failed in our goal of having a single PSRO for the state, we went ahead, with colossal work being done particularly by Dr. Frank Sohmer and Mr. Dan Mainer, with the formation of our North Carolina Peer Review Foundation. Even though most of us are convinced that this is a bad law, there is still no question whatsoever that the physicians must be accountable to the taxpayers for how they spend the taxpayers' money. Because we all have agreed with this view, we persisted not only in forming the Peer Review Foundation, but also in getting the contract with the State Department of Human Resources for peer review of nursing homes and mental hospitals in the state. As I mentioned in my message to the House of Delegates, an application for the so-called Support Center Category for our Peer Review Foundation has been submitted to be a basic aid in helping the eight areas set up their own PSROs.

MEDPAC AND LEGISLATION

All of these threads obviously are intertwined, but I must mention the critical matter of the PAC movements on the national, state and local levels. As I stated in one of my newsletters, it is crucial that we let our representatives in all government categories know how we feel about the myriad angles of health legislation. It is also crucial that we let our own representative know, if it be the case, that we are supporting him. Legislative activity has become increasingly crucial and, along with other interest groups, the "lobby" has developed somewhat new connotations. In basic politics there is no question that the various lobbies are absolutely essential. I merely educating legislators faced with so many facets of legislation that it is impossible for any one person to assimilate them. Lobbying could be better referred to as a form of continuing education for legislators.

THE AUXILIARY

Another constant thread with us, which is close to all of us personally and as an organization, is our own medical auxiliary. I have let their leaders know that, in traveling to AMA functions, I have found that our North Carolina Medical Auxiliary enjoys a very high national reputation; in fact, they probably enjoy a better reputation than we do!

THE PRESIDENCY

A thread that takes a little time to sink in, as it goes through the two years of President-elect and President, is that your Society's office of the Presidency enjoys more respect than you might guess.

ne and time again, when there has been a chance representation to people in Washington—for instance, when it would seem that some other parties could have more influence—all have seemed to see that the President of the State Medical Society could have more clout than almost any other interested party in the state. This, of course, is a tremendous tribute to the working of our organization, particularly to my predecessors. Speaking of respect, which I touched on in my inaugural address, the past year has evidenced that the public's trust in their physician has stayed at the top of the list, whereas their respect for politics and government plummeted to a new low. In talking with your legislators, it would be worthwhile to remind them that we do, indeed, enjoy this respect of the public, and that it would be wise for them to listen to our commendations.

CRISIS IN HEALTH CARE—FALLACY

For years, having lived with the outpourings of propaganda, usually from government and social planners, that there is a horrible crisis in health care, I stress that this warning is very far from the truth. We, of course, must face our deficiencies, of which we are reminded at every turn. But, indeed, we should hesitate to stress the positive side of our medical care system. One basic truth which comes home clearer and clearer is that the deficiencies quoted to us in comparison with other countries, are in no way caused by our medical care system. It is the very reverse. Again, I recommend that everybody read the book, *The Case for American Medicine*, by Harry Schwartz. Another truth which is borne out repeatedly is that, in spite of the maldistribution of physicians, access to health care is far down the list in the major determinants of the health of an area or a nation. Consider the major facets—poverty, poor education, poor housing, and poor transportation; and perhaps the largest factor of all is “life style,” the abuses that human beings are responsible for perpetrating on themselves. Having a physician available on every street corner would not correct these fundamental deficiencies. A recent illustration of the “crisis in health in this country” can be seen in President Nixon’s open news conferences held in the past several months. These question-and-answer periods have been open and free for all, with concentration on the real crises in this country. But with that, “health” has not been mentioned by one reporter, at any time.

MEMBERSHIP

Our membership has continued to climb at a healthy rate, and I believe physicians, as a whole, across the state and the country, are becoming convinced, as they should, that the only way they can exert any influence on some of the horrors that face us is to be active in their own medical societies. I am also pleased that we are seeing an influx of

young physicians, which is, of course, basic. Last year I was set back on my heels when I overheard someone say, “I’m tired of going to Pinchurst and finding the State Society run by a bunch of old men.” I cannot leave “membership” as a category, without mentioning another organization that you have heard me recommend many times—that is, the North Carolina Association of Professions. Some of our dues go to this organization, and, as has become apparent, if one merely pays the dues, he could probably justly ask, “What is it doing for me?” The organization has indeed done great things for all the professions in the past, and will continue to in the future, but the benefits are not fully realized until we attend the meetings. It is a heartening and refreshing experience to meet with the other professions and learn of their problems and successes which are amazingly similar to ours. One Virginia member characterized this organization as a “sleeping giant.”

MEDICAL EDUCATION

One of the biggest changes for the future of medical education in this state has taken place during the past year. This has involved the combined efforts of our three medical schools, the Governor, the State Legislature, and most important of all, the practicing physicians. I speak of the growing establishment of Area Health Education Centers—AHECs. Depending, perhaps, on where you live, you may regard the continuing efforts to expand ECU Medical School as a priority of equal importance, down the road. In our Society, the innovation of making our General Sessions primarily a place for continuing medical education is a step forward.

I have left for the last on the list the one thread that I hope will bear more fruit than any other innovation. The time has come for us to concentrate on our “rotten apples.” As mentioned in my message to the House of Delegates, it becomes increasingly obvious that there is only a fraction of physicians in our Society and elsewhere who give ammunition to our critics. We can identify them, but we have not had the clout to do as much as we want with them, and we hope that with our newly proposed legislation we can achieve this goal.

CONCLUSIONS—LOOKING TO THE FUTURE

Depressing thoughts

I have become tired, in the last two years, of hearing various speakers say that the question is not “whether” we should have national health insurance, but “when.” I suppose they are right, and the bills before Congress are indeed a source of considerable depression, should we go through most of them, barring, of course, the Medi-Credit legislation sponsored by the AMA.

Hopeful thoughts

It did all of our hearts good when, on January 25 at a press conference, our AMA President, Rus-

sell Roth, announced that the minute Casper Weinberger implements his directive for preadmission certification of hospital admissions, "we are going to take him to court." The encouraging thing is that the powers that be in government did, indeed, very actively back off on that item.

Certain thoughts

We can be sure that we are going to be faced with "future shock," as indicated by Alvin Toffler, the author of a book by that name. Here again, we must learn to cope, at an accelerating pace, or we are going to get left far behind.

Of crucial importance in the up-coming election is that the next Congress will probably be the body politic that will determine what type of national health insurance we may have imposed upon us.

Lastly, a final bit of advice. We should openly admit our real defects and try to correct them. But we should not forget to stress the "gut" issues of the superior quality of our medical care system, with its fundamentals. Preserving the sanctity of the individual is the reason for our better medical care, which many of us forget is the bedrock of our Constitution. It is our responsibility to continue in our effort to help each patient and to fight for his rights as an individual, as well as for our own.

In the exhibition of medicine, regard should not only be had to simplicity, but likewise to elegance. Patients seldom reap much benefit from things that are highly disagreeable to their senses. To taste or smell like a drug is become a proverb; and to say truth, there is too much ground for it. Indeed, no art can take away the disagreeable taste and flavour of some drugs, without entirely destroying their efficacy; it is possible, however, to render many medicines less disgusting, and others even agreeable; an object highly deserving the attention of all who administer medicine.—*William Buchan: Domestic Medicine, or a Treatise on the Prevention and Cure of Diseases by Regimen and Simple Medicines, etc., Richard Folwell, 1799, p. 438.*

Message of the President To the House of Delegates

George G. Gilbert, M.D.

CUSTOM dictates that I give a summary of the major events and activities involving our Society during the past Society year. This report focuses on the state and on North Carolina Medical Society activities, obviously intertwined with myriads of other activities, and an incredible variety of activities locally and outside the state.

As I have worked for and with you as your President, I find that words cannot express my ever-increasing impression of what an outstanding organization we have. I have taken great pride in your activities, particularly when compared with the activities of other state medical societies. Perhaps our greatest asset in this light is our universal ability to communicate in our dealings with many other people and organizations. When in medical circles outside the state, you can hold your head high, realizing the value of our communications as an asset, having been built from bedrock over a period of many years.

Some of the other areas of our communications involvement (which other states do not enjoy with their respective organizations and institutions) include (1) the North Carolina Hospital Association, (2) the insurance carriers and our two major committees on claims adjudication — the Blue Shield Committee and the Insurance Industry Committee, (3) the three medical educational institutions in the state—the University at Chapel Hill, the Bowman Gray School of Medicine, and Duke University, (4) the state and local government, including the interrelationships involving health facets directly and the constant checker game with the State Legislature,

(5) the North Carolina State Pharmacy Association, (6) the North Carolina Nurses' Association, (7) the North Carolina branch of the American Cancer Society, and (8) the North Carolina Chapter of the American College of Surgeons. Needless to say, they are too numerous to list. I have merely hit the high spots.

The "Compilation of Annual Reports" further illustrates the multiple activities that go on within the Society. Nearly all of these publications have reported the major activities continued in their respective areas.

In view of the impressive features regarding the magnitude and scope of the responsibilities of our Medical Society members, including those of the officers and staff—your dedicated servants—it is my privilege to summarize some of the major developments of this past year. Our progress must be viewed within the context of the incredible variety of hard work continually accomplished in the other areas to which I have referred.

First, the most crucial Society activity this past year has been in our dealings with the PSRO matter. Those of you who have followed both the national and our state publications know of the developments in this area. As we predicted a year ago, although we did everything in our power to have Washington approve a statewide PSRO, as did many other states, all our efforts were of no avail. Our representatives were greeted politely, but we lost for rather slim reasons, whereas our sister state of Georgia was granted its single PSRO. During the year, our North Carolina Medical Peer Review Foundation, Inc., became increasingly active, and outside of PSRO developed a contract with the State Department of Human Resources to conduct peer review, as required under Social Security, for our nursing homes and mental

Presented before the House of Delegates, North Carolina Medical Society, Pinehurst, May 19, 1974.
For reprint requests to Dr. Gilbert, 1 Doctor's Park, Asheville, N. C.

hospitals. Under the changing rules of the ball game, it has now become appropriate for our North Carolina Peer Review Foundation to apply to Washington for a so-called support center grant to help the eight designated PSRO areas to get off the ground with their own applications for planning grants. I view our situation as similar to that of the AMA in which a colossal amount of work has been done by dedicated people tooling up to cooperate with the government in implementing this law. On the other hand, many of us, as well as the AMA, have realized that it is indeed a bad law.

Perhaps the second most significant activity was the House of Delegates' mandating continuing medical education as a necessity for membership in our Society. This action led to national publicity and dovetailed the development of Area Health Education Center programs, fostered primarily by the University of North Carolina, the State Government, and the Regional Medical Program. Both these developments are viewed as having great significance, and they should be of far reaching benefit to our Society.

As a third activity, I mention the colossal labors of our Legislative Committee, and all others concerned (particularly while the Legislature was in session), on the controversial ECU question. There were many other bills screened by our Legislative Committee, and often prompt action was taken in the pursuit of our goals.

A fourth significant piece of legislation, regarding drunk drivers, came from our mutual efforts, in behalf of the Department of Motor Vehicles.

Fifth, a novel development which came as a result of the mutual meetings of our Pharmacy Committee and the Pharmacists' Medical Committee was the form designed for use by our pharmacists and physicians in an attempt to improve the service between the physician and his office staff, and the pharmacist.

Sixth, we were asked to assist the Commissioner of Mental Health in upgrading the salaries for the physicians in that department, not only in the mental health hospitals but in their clinics. We were asked to encourage more cooperation and interplay between these facilities and the county medical societies where they are located.

Seventh, a colossal amount of work has gone into setting up the program to make our general session an opportunity for continuing medical education.

Finally, last year I set as one of my major goals the task of trying to improve our methods of dealing with so-called "rotten apples." As we have attended our various claims adjudication committees and our professional insurance committees, we have realized that the possible incompetent or dishonest physician are readily identifiable and represent a very small group. Yet it has been a source of great frustration that we have not sunk our teeth into our Medical Practice Act to improve the situation. With the recommendations of an ad hoc committee, and action by the Executive Council, we are going forward with an amendment to the Medical Practice Act, which we hope will add to its present provisions, so that a physician may be investigated or may have his license revoked for "medical incompetence." With this in mind, I have every hope that you will go forward with Report O and the recommendations from the Executive Council.

CONCLUSIONS

We must not forget that our number one priority is to improve the health of our patients. That goal is the beginning and the end of our very being.

Throughout the year, I have tried in all my activities to reflect your desires and mandates, some of which are still controversial. Another broad, basic precept that has guided me—one which most of you prove every day in your own practice—is that the highest quality of medical care must continue to be based on the mutual respect and trust developed between physician and patient. It is especially important to keep this in mind, since every national health insurance scheme will tend to increase the difficulty for you to maintain that relationship.

In this brief summary, although I have mentioned no names, my deep gratitude goes out to the many wonderful people who have helped me and the Society throughout the year. They know who they are. Crises seem to crush in on us faster than we can assimilate them in these critical times, so I urge all of you to be ever aware of how you can influence the future practice of medicine in North Carolina and possibly in the whole country.

Notwithstanding the extravagant encomiums which have been bestowed on different (ointments, liniments, and cerates), with regard to their efficacy in the cure of wounds, sores, etc., it is beyond a doubt, that the most proper application to a green wound is dry lint. But though ointments do not heal wounds and sores, yet they serve to defend them, deterging, destroying proud flesh, and such-like.—*William Buchan: Domestic Medicine, or a Treatise on the Prevention and Cure of Diseases by Regimen and Simple Medicines, etc., Richard Folwell, 1799, p. 457.*

Control of Diseases Preventable by Active Immunization in North Carolina—Past, Present, and Future

J. N. MacCormack, M.D., M.P.H.*
and
Jacob Koomen, M.D., M.P.H.†

THE topic chosen for presentation to the Conjoint Session this year represents one aspect of one of the oldest public health programs—the attempt by communities to protect themselves from communicable disease epidemics. Indeed, a number of early state, county and city health departments was organized specifically to establish ongoing agencies responsible for quarantine and sanitation matters. As an example, in June 1911, Guilford County became the first North Carolina county to employ a full-time health officer; his primary duty was to combat hookworm disease.¹

SMALLPOX

Although a few immunizing agents were available at the turn of the century, control of communicable disease outbreaks at that time relied heavily upon quarantine measures. Consider the following situation described in an 1894 report of the Secretary of the State Board of Health:

In our last issue we called attention to the rapid spread of smallpox

over the United States and sounded a note of warning. Since that time the disease has made its appearance in our own State—in Cherokee; but thanks to the prompt and vigorous action of the County Superintendent of Health looking to the quarantining of the patient he did not abide with us long. Rather than be quarantined he left the State, thereby demonstrating in a very practical and satisfactory manner the value to the community of an organized health department with an alert health officer."²

One must remember that, even as late as the 1890s, smallpox vaccination continued to meet with much resistance:

"Most persons not acquainted with the temper of our people would say at once make vaccination compulsory. That sounds well, but it would be *vox et preterea nihil*. In the first place, in the opinion of the writer, our Legislature could not be induced to enact such a law; and if it could the law would, unsupported by public sentiment, be a dead letter. As to what public sentiment on this subject is the following will illustrate: At the conjoint session of the State Board of Health with the State Medical Society in Wilmington in 1892 one of our County Superintendents reported that going to a public school-house to vaccinate the children, according to a previous ap-

pointment, he found the house shut up and the entire school, teacher and all, taken to the woods."²

With the realization that early quarantine and isolation procedures for smallpox often did more to discourage seeking medical attention and vaccination, the quarantine law for this disease was repealed during the first decade of this century, and a statute requiring smallpox vaccination was enacted in 1911. As shown in Table 1, however, one cannot state that the enactment of this statute had any immediate effect upon smallpox morbidity and mortality in the state. The last smallpox

Table 1
Reported Smallpox Cases and Deaths,
North Carolina, 1914-1930

Year	Cases*	Deaths
1914	—	26
1915	—	11
1916	—	13
1917	—	13
1918	983	3
1919	2,322	9
1920	2,961	28
1921	2,513	20
1922	1,409	8
1923	3,352	13
1924	3,845	29
1925	1,920	5
1926	1,594	14
1927	1,702	15
1928	2,419	17
1929	589	2
1930	556	6

* Smallpox cases became reportable in 1918.

¹ Read before the Conjoint Session, North Carolina Medical Society and the North Carolina Division for Health Services, Pinehurst, N.C., 12, 1974.
² Read, Communicable Disease Control, Division of Health Services, Director, North Carolina Division of Health Services.
Print requests to Dr. Koomen, North Carolina Division of Health Services, Department of Health Resources, P. O. Box 2091, Raleigh, N.C. 27602.

death was recorded in 1943, and the last case was reported in 1948. Since that time, until 1973, smallpox vaccination of children continued as a requirement of North Carolina law. Our adult population remained largely unvaccinated. In the early 1960s a group of physicians working in the Smallpox Eradication Program of the National Communicable Disease Center (now the Center for Disease Control, but still "CDC") began to study complications of vaccination with the vaccinia virus. In 1963, for example, seven persons in the United States died from postvaccinal encephalitis or eczema vaccinatum, and an additional 426 cases of nonfatal complications were identified.³ This and subsequent studies, coupled with a world-wide campaign by the World Health Organization to eradicate smallpox, finally led to the controversial recommendation by the United States Public Health Service Advisory Committee on Immunization Practices in 1971 that routine smallpox vaccination of children be discontinued in this country—a recommendation endorsed by the Committee on Infectious Diseases of the American Academy of Pediatrics. The 1973 General Assembly, after considerable debate, enacted a change in the state immunization law to permit the Commission for Health Services to determine whether smallpox vaccination of children should be required. This statute was ratified on May 22, 1973, and on the following day the Commission for Health Services decided to omit smallpox from the list of required

Table 2
Deaths From Selected Communicable Diseases,
20 North Carolina Municipalities,*
1906-1907

Disease	Deaths	
	1906	1907
Typhoid	140	140
Malaria	58	66
Pertussis	37	38
Diphtheria	12	16
Measles	8	25

* Charlotte, Durham, Elizabeth City, Fayetteville, Greensboro, Henderson, Marion, Oxford, Raleigh, Rocky Mount, Salem, Salisbury, Southport, Tarboro, Wadesboro, Washington, Waynesville, Weldon, Wilmington, and Wilson

Table 3
Reported Cases and Deaths By Five-Year Periods for Diphtheria, Pertussis,
and Tetanus, North Carolina, 1920-1969

Years	Diphtheria		Pertussis		Tetanus*	
	Cases	Deaths	Cases	Deaths	Cases	Deaths
1920-24	25,460	1,864	53,908	1,934	—	268
1925-29	17,832	1,554	52,827	1,543	—	171
1930-34	12,910	1,107	50,676	1,375	—	159
1935-39	10,933	842	43,652	1,005	—	147
1940-44	5,407	359	36,752	654	—	72
1945-49	3,872	229	15,538	288	—	74
1950-54	1,330	70	6,823	135	—	67
1955-59	256	15	3,044	67	56	35
1960-64	52	4	667	27	63	45
1965-69	7	1	297	1	27	22

* Tetanus did not become a reportable disease until 1952.

immunizations in North Carolina. Many physicians had already begun refusing to vaccinate their patients with vaccinia virus, citing as a medical contraindication the recommendations of the Public Health Service and American Academy of Pediatrics that this not be done.

Today we find smallpox endemic in only five countries, four of which — Bangladesh, India, Nepal, and Pakistan—are on the Indian subcontinent. The fifth endemic country, Ethiopia, is on the verge of eradicating the disease. India, probably the last frontier of smallpox, will be subjected to an intensified eradication program through the remainder of 1974, so that the worldwide eradication of this ancient scourge might be achieved in the near future. If this is achieved—and indications are that it will be—it will mark the first time man has ever intentionally and successfully eradicated a disease from the world. Let us hope for success.

"DPT" AND POLIO

Now let us discuss some historical aspects of other communicable diseases preventable by active immunization. Smallpox was not the only communicable disease problem of the early 1900s, as shown in Table 2. Interestingly, the reduction in typhoid morbidity today can be attributed almost entirely to improvement in sanitation rather than to the utilization of typhoid vaccine. Malaria control has also been based on environmental manipulation.

Diphtheria, on the other hand, is not a disease that yields to sanitary

practices alone, if at all. The first breakthrough in immunization was the production of diphtheria antitoxin in 1894 by Roux and Martin. Diphtheria toxoid was developed in the early 1920s. Pertussis vaccine became available a few years later but was not effectively standardized until the late 1940s. Tetanus toxoid, the third component of the "DPT" vaccine in common use today, was available in the late 1920s but did not enjoy widescale use until the World War II years. The General Assembly added these vaccines to the list of immunizations required for North Carolina children in 1933, 1945, and 1957, respectively. Table 3 shows the downward trend in morbidity and mortality for these three

Table 4
Reported Poliomyelitis Cases and Deaths, North Carolina, 1948-1968

Year	Cases	Deaths (including late effects)
1948	2,516	143
1949	229	16
1950	756	24
1951	314	11
1952	538	24
1953	926	35
1954	732	22
1955	463	12
1956	315	8
1957	233	3
1958	74	3
1959	313	23
1960	85	9
1961	19	6
1962	15	6
1963	7	2
1964	9	1
1965	0	2
1966	0	4
1967	1	2
1968	1	0

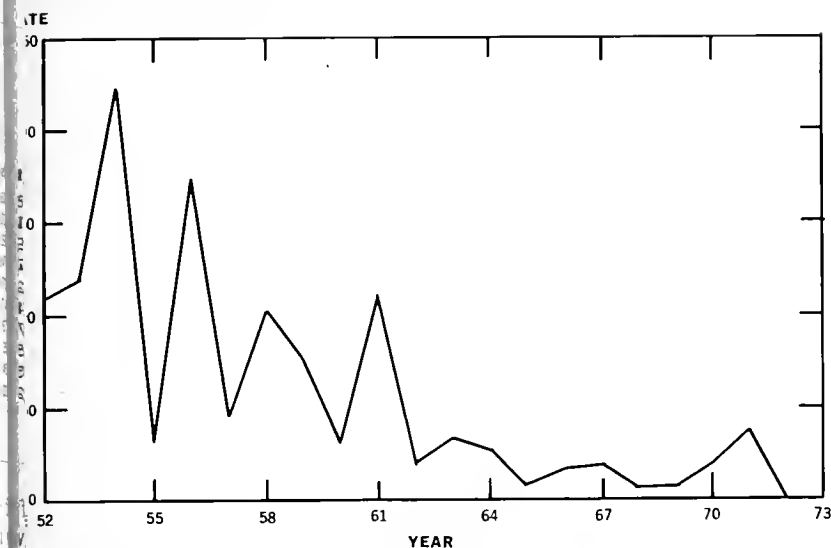


Fig. 1. Measles morbidity rates per 100,000 population, North Carolina, 1952-1973.

diseases. As we shall see, some work remains to be done in their control.

The dramatic story of poliomyelitis vaccine development need not be reiterated here, for it unfolded not so long ago. The acceleration in the decline of morbidity and mortality from this disease after the licensure of Salk's inactivated vaccine in 1955, continuing after Sabin's oral polio vaccine became available in 1962, is quite impressive (Table 4). In 1959 the Legislature made polio immunization mandatory for children.

In the early 1960s, the advent of mass immunization campaigns in the form of "Polio Sundays" was an important development in its own right. Thanks to the support and participation by county medical societies, almost three million North Carolinians received oral polio vaccine in 1964. A technique for rapidly reaching large groups of people with a new vaccine, the mass campaign is quite effective. However, it cannot be used as a substitute in lieu of an effective, ongoing immunization program. Even though the National Foundation has progressed to the field of other defects, we are reminded by reports from other states that the polio virus is not dead and that we cannot afford to forget it.

MEASLES, MUMPS, AND RUBELLA

With the advent of the 1960s, development of new vaccines concen-

trated on attenuated live viral preparations to combat the common childhood diseases of the day. Licensure of measles (1963), mumps (1967), and rubella (1969) vaccines paved the way for new mass immunization programs. There was a definite decline in measles morbidity as a result of the introduction of the vaccine (Figure 1), but a resurgence of the disease in 1970 and 1971 sparked a new interest in public campaigns. Measles immunization given before the age of two years became an added requirement of the state immunization law in 1971. Rubella was under good control in 1972 and 1973 in North Carolina; 1974 will be a crucial year in determining whether we can keep it suppressed in the state. The disease continues to be out of control in a number of other states.

Rubella vaccine has been one of the most controversial developments in the history of immunoprophylaxis. Suffice it to say that concentration on the immunization of one to 12-year olds has not eradicated the disease, as evidenced by last spring's rubella outbreaks on several college campuses in the state. The Student Health Service at the Chapel Hill campus of the University of North Carolina registered 710 patients with rubella between January 7 and May 6, 1973. A few cases were seen in the local senior high school, but younger Chapel Hill-Carrboro area children escaped

this epidemic. No cases of maternal rubella were recognized and no rubella syndrome-affected infants have been born in the community. However, the risk of exposure of nonimmune pregnant women does exist in such situations, and the prevention of rubella infection in pregnant women—the goal of any rubella immunization program—should encompass individualized immunization of childbearing-age women, in addition to immunization of children.

Mumps vaccine has rightfully been assigned a lower priority than either measles or rubella vaccine. Although incorporated as a component of "M-M-R" vaccine since 1971, its use has not been emphasized in public health programs in this state. Perhaps its day is coming.

IMMUNIZATION STATUS OF NORTH CAROLINA'S CHILDREN

What can be said about the current immunization status of North Carolina's citizens? Our efforts have traditionally been concentrated on immunizing children, and perhaps—particularly in the realm of tetanus and diphtheria prevention—more attention should be directed toward protecting our adults as well. This is borne out by observing that the average age of patients contracting tetanus has been creeping upward for several years.

A survey of the immunization status of two-year-olds in 1972 showed some striking deficiencies. Five percent of this group had received no immunizations at all, 18 percent had not received three doses of DPT, 35 percent had not received three doses of oral polio vaccine, 33 percent had not been immunized against measles, and 47 percent had not received rubella vaccine. Only 38 percent had completed a minimally-defined basic series of three doses each of DPT and polio vaccine, and measles and rubella vaccines.⁴ The survey will be repeated this summer to assess what changes may have occurred.

A survey involving first-graders

Table 5

Percentage of First Grade Public School Children Meeting Minimum Immunization Requirements; Ten Most Populous and Ten Least Populous North Carolina Counties, September, 1973

County	Percent Meeting Requirements
10 Most-populous:	
Mecklenburg	77.5
Guilford	82.9
Wake	77.0
Cumberland	87.2
Forsyth	74.3
Gaston	81.3
Buncombe	89.2
Durham	75.5
Onslow	84.5
Davidson	90.1
Average	81.0
10 Least-populous:	
Alleghany	86.0
Perquimans	97.6
Swain	92.1
Dare	91.5
Currituck	92.2
Graham	78.4
Hyde	92.0
Camden	96.4
Clay	86.8
Tyrrell	84.0
Average	90.1

entering our public schools was conducted last fall. For the state as a whole, 85.2 percent of these children met the requirements of the immunization law: three doses each of DPT and oral polio vaccine, and

measles vaccine. Surprisingly, some of the most populous counties had the lowest percentages of first-graders meeting the minimum requirements (Table 5).⁵

The United States Public Health Service has evidenced concern in recent years regarding declining immunization levels; it points to outbreaks of polio, diphtheria, and measles in a number of states as dire portents of the future unless an increased effort is made in improving these sagging levels. October 1973 was designated as "Immunization Action Month" to kindle interest in improving the status quo.^{6, 7}

As, during the late 1960s, when federal support of measles vaccine programs was supplanted by Congressional interest in the new rubella vaccine, the development of new vaccines seldom awaits optimal utilization of already licensed products; if not pursued at the expense of existing programs, perhaps this is as it should be. A vaccine to prevent group C meningococcal infection has recently been licensed for use in the military and "high risk groups," yet to be defined by the Bureau of Biologics of the Food and Drug Administration. A field trial of an inactivated type B *Hemophilus influenzae* vaccine is currently underway in

Charlotte. Other vaccines are also in various stages of development.

SUMMARY

We know that diseases preventable by active immunization are not conquered overnight, that serodominance does vaccine alone eradicate disease, and that there is considerable overlap in the stages of vaccine development, utilization, and obsolescence. The primary role of the public health worker and primary care physician is in the utilization stage, for only through proper utilization of available vaccines can diseases such as diphtheria, pertussis, tetanus, polio, measles, and rubella be controlled.

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Early in the morning the patient is to take in any liquid, two or three drachms, according to his age and constitution, of the root of the male fern reduced into a fine powder. About two hours afterwards he is to take of calomel and resin of scammony, each ten grains; gum gamboge, six grains. These ingredients must be finely powdered, and given in a little syrup, honey, treacle, or any thing that is most agreeable to the patient. He is then to walk gently about, now and then drinking a dish of weak green tea, till the worm is passed. If the powder of the fern produces nausea, or sickness, it may be removed by sucking the juice of an orange or lemon.

This medicine, which had been long kept a secret abroad for the cure of the tape-worm, was some time ago purchased by the French King, and made public for the benefit of mankind.—William Buchan: Domestic Medicine, or a Treatise on the Prevention and Cure of Diseases by Regimen and Simple Medicines, etc., Richard Folwell, 1799, p. 464.

Carpal Desmotomy: A Technical Note

Timir Banerjee, M.D., and
John N. Meagher, M.D.

THE exact cause of carpal tunnel syndrome is not known. Several factors, e.g., osteoarthritis, collagen disease, myxedema, and repeated trauma play an important role in the precipitation of this compression syndrome.¹⁻⁵ A case of carpal tunnel syndrome associated with rubella immunization has been reported recently.⁶

Ordinarily, subjective symptoms appear weeks or months before demonstrable abnormalities are seen on routine examination. Accentuation of the symptoms, as seen in flexion or extension of the wrist, or a positive Tinel's sign at the wrist may aid in making the diagnosis, but these symptoms or signs do not occur consistently. The accompanying pain is often diffuse and may be felt in the forearm. As noted by McCormack,³ the pain is usually worse at night. Distressing numbness frequently occurs, and paresthesia of the hand, usually sparing the little finger and the ring-finger, may be present. According to their histories, many patients say that they often wake up in the middle of the night and shake their hands in a "jerky motion" to get relief from pain and paresthesia. In advanced cases or in

instances of severe pain, the patient may be weak and unable to "pinch."

Electrodiagnostic studies help to

CARPAL TUNNEL SYNDROME

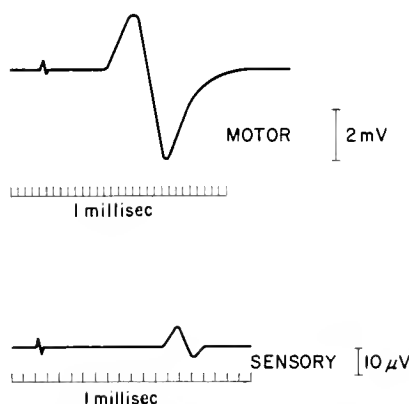


Fig. 1. EMG of carpal tunnel syndrome: (a) motor nerve conduction delay (normal up to 4.5 msec); (b) sensory nerve conduction delay (normal up to 3.5 msec).

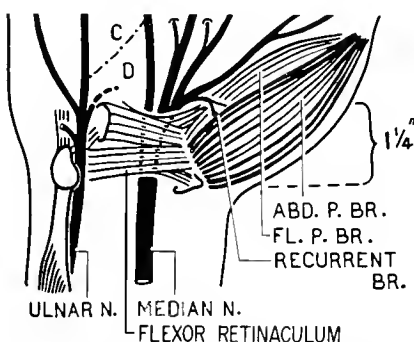


Fig. 2. Semidiagrammatic picture of the wrist showing the position of the recurrent branch of median nerve.

demonstrate the delay in median nerve conduction at the wrist; they are also reliable in following up the patient's recovery. When a bipolar supramaximal stimulus is administered to the median nerve by an electrode at the proximal flexor crease, and the evoked response in the thenar musculature is recorded by a surface or a coaxial needle-electrode, the delay should not exceed 4.5 msec (Figures 1-3).

There is considerable dispute among orthopedic, plastic and neurosurgeons regarding the technique of carpal desmotomy. This paper is



Fig. 3. Skin incision.

From the Division of Neurological Surgery, University of North Carolina School of Medicine, Chapel Hill, N. C. 27514 (Dr. Banerjee) and the Ohio State University School of Medicine, Columbus, Ohio (Dr. Meagher). Reprint requests to Dr. Banerjee.



Fig. 4. Appearance of the carpal ligament (flexor retinaculum) after the retractor is placed.



Fig. 5. Placement of the Sachs dissector between the median nerve and the lower end of carpal ligament and the extended fat identifying the distal border of the ligament.



Fig. 6. Flattened relaxed nerve after pressure is released.

a report on the value of this simple technique, of which the striking results are negligible morbidity and the immediate relief of pain, numbness, or minimal weakness in the distribution of median nerve in the hand.

OPERATION

In order to reduce morbidity and the inconvenience to the patient, we prefer to operate on one hand at a time if there is evidence of bilateral disease.

The patient's hand and forearm are cleaned with an antiseptic solution while he is awake. A pneumatic tourniquet is placed around the arm. Esmarch's rubber tourniquet is used to compress the hand, starting from the fingers and progressing proximally to the middle of the forearm while the hand is elevated. The general anesthesia used is a combination of thiopental sodium (Pentathal) and nitrous oxide. An endotracheal tube is unnecessary. The pneumatic tourniquet is inflated and the Esmarch tourniquet is removed. The fingers are draped within the operative field to allow movements of the thumb to be observed when the median nerve is stimulated, thus confirming the preservation of the recurrent branch and elevation

threshold to stimulation for contraction.

A vertical incision 3 to 4 cm long is made on the palm, slightly ulnar to the midline, approximately 2 mm from the distal crease at the wrist. This incision is designed to spare the recurrent branch of the median nerve supplying the thenar muscles (Figures 2 and 3). Hunt and Luckey¹ discuss the value of sparing the palmar cutaneous branch of the median nerve although there is overlap by the branches from the ulnar nerve and radial nerve. After a mastoid self-retaining retractor is placed, the distal end of the transverse carpal ligament (flexor retinaculum) can be recognized (Figure 4). Usually at this point, slightly whitish-yellow fat extrudes spontaneously at the lower border of the carpal ligament. A Sachs dissector is placed between the ligament and the nerve, and the vertical incision is made in succession until the proximal edge of the ligament is divided and the nerve is free (Figure 5). Consequently, the Sachs dissector rides freely above the nerve. The nerve often appears to be red and flattened; the fat normally present between the ligament and the nerve is absent (Figure 6). Metzenbaum scissors are used to

make the final cuts, until the scissors freely enter Parona's space. Parona's retroflexor space in the distal forearm is limited by the flexor digitorum profundus and the flexor pollicis longus in its synovial sheath, which forms the anterior boundary; the pronator quadratus and the interosseous membrane form the posterior boundary. Proximally, Parona's retroflexor space is continuous with the intermuscular spaces of the forearm; distally, it reaches the level of the wrist and is potentially connected with the deep palmar space. It is usually necessary to make one or two cuts distally as well, until the scissors appear to be free in the palm. We routinely perform a biopsy of the ligament.

After irrigation the wound is closed in two layers; 4-0 silk is used for the subcutaneous tissue and 000 nylon is used for the skin. The tourniquet is removed after a light pressure dressing is completed with an ace bandage. The entire procedure takes approximately 15 minutes.

Our follow-up has shown excellent results; only one patient of 50 who were operated on by using the above technique required re-exploration because of persistence of symptoms. Four patients ex-

pined of tenderness at the site of
 the incision, and they expressed
 minimal discomfort while working,
 even after six weeks. However, nerve
 conduction studies showed improve-
 ment in only two patients. A trial
 of men of Decadron, administered
 every six hours for three days, im-
 proved the symptoms of all but one
 patient.

We believe that this simple surgi-
 cal technique reduces the operating
 time and is effective in alleviating
 symptoms. The scar is hardly notice-
 able after approximately six months.

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Atrahilarian: An epithet commonly applied to people of a certain temperament, marked by a dark complexion, black hair, spare diet, etc. which the ancients supposed to arise from the *atra bilis*, or the black bile.—*William Buchan: Domestic Medicine, or a Treatise on the Prevention and Cure of Diseases by Regimen and Simple Medicines, etc.*, Richard Folwell, 1799, p. 473.

Editorials

SUGGESTIONS FOR AUTHORS

The NORTH CAROLINA MEDICAL JOURNAL welcomes original contributions to its scientific pages, expecting only that they be under review solely by this JOURNAL at a given time, and that they follow a few simple guidelines. The guidelines are as follows:

1. Subject Matter

Educational articles, especially those in which particular applications to the practice of medicine in North Carolina are developed, are one of the main objectives of this JOURNAL.

Articles reporting original work by North Carolina physicians are invited, whether the work is done in a clinic, a laboratory, or both. The editor and his consultants will evaluate the work by the usual criteria, including a proper discussion of previous work, control observations, and statistical tests where indicated.

Historical articles, especially those dealing with local history, are considered of real value and interest.

2. Manuscripts

An original and a carbon copy of the manuscript should be submitted, one for review by the editorial staff, the other by referees. The manuscript should be typed on standard-size paper, double-spaced, with wide margins (one inch on each side).

3. Bibliographic References

References to books and articles should be indicated by consecutive numerals throughout the text and then typed, double-spaced, on a separate page at the end of the manuscript. Books and articles not indicated by numerals in the paper should not be included.

References will be much more valuable to the reader if they are given in a proper form and contain the full information necessary to locate them easily. The NORTH CAROLINA MEDICAL JOURNAL follows the form used in the journals of the American Medical Association and the *Index Medicus*, giving the author's surname and initials, title of the article, name of the periodical, volume, inclusive page numbers, and the date of publication. It is believed that this style makes it easier for the reader to judge whether the reference is likely to prove useful to him, and enables him to locate it more quickly.

4. Tables and Illustrations

Tables and legends for illustrations should be typed on separate sheets of paper. The illustrations should be glossy black-and-white prints or line drawings. It is necessary to obtain permission from the author or publisher to reproduce illustrations which have been published elsewhere. Costs in excess of \$15.00 for illustrations are borne by the author. Costs for setting of tables are also borne by the author as are charges for art work which might be needed for proper printing of figures.

² Elected at this year's annual meeting; other officers are continuing on a tenure basis.

5. Style

The style followed by this JOURNAL will be, in general, that outlined in the Style Book issued by the Scientific Publications Division of the American Medical Association, John Talbot, M.D., director. All manuscripts are subject to editorial revision for such matters as spelling, grammar, and the like.

By following the above suggestions, writers will greatly expedite the publication of papers accepted by the NORTH CAROLINA MEDICAL JOURNAL.

TRANSACTIONS OF THE HOUSE OF DELEGATES NORTH CAROLINA MEDICAL SOCIETY

Pinehurst, May 19-21, 1974

The House of Delegates of the North Carolina Medical Society met in Pinehurst during the annual session of the Society. Reference committees of the House had excellent discussions and participation. For the first time, the House of Delegates this year had delegates from specialty societies; the number of such delegates will increase, of course, as new sections continue to be created.

Elections

The House elected the following officers for the current year:

President: Frank R. Reynolds, M.D., Wilmington
President-elect*: James E. Davis, M.D., Durham
First Vice-President*: Jack Hughes, M.D., Durham

Second Vice-President*: M. Frank Sohmer, M.D., Winston-Salem

Secretary: (1973-1976): E. Harvey Estes, M.D., Durham

Speaker*: Chalmers R. Carr, M.D., Charlotte
Vice-Speaker*: Henry J. Carr, Jr., M.D., Clinton
Past President: George G. Gilbert, M.D., Asheville
Executive Director: William N. Hilliard, Raleigh

Councilors and Vice Councilors

First District (1977):

Councilor*: Edward G. Bond, M.D., Edenton
Vice Councilor*: Joseph A. Gill, M.D., Elizabeth City

Second District (1976):

Councilor: J. Benjamin Warren, M.D., New Bern
Vice Councilor: Charles P. Nicholson, Jr., M.D., Morehead City

th District (1976):
 Councilor: E. Thomas Marshburn, Jr., M.D.,
 Wilmington
 Vice Councilor: Edward L. Boyette, M.D., Chin-
 quapin
 th District (1977):
 Councilor*: Harry H. Weathers, M.D., Roanoke
 Rapids
 Vice Councilor*: Robert H. Shackelford, M.D.,
 Mt. Olive
 th District (1975):
 Councilor: Albert Stewart, Jr., M.D., Fayetteville
 Vice Councilor: August M. Oelrich, M.D., Sanford
 th District (1977):
 Councilor*: J. Kempton Jones, M.D., Chapel Hill
 Vice Councilor*: W. Beverly Tucker, M.D.,
 Henderson
 th District (1975):
 Councilor: Jesse Caldwell, Jr., M.D., Gastonia
 Vice Councilor: William T. Raby, M.D., Charlotte
 th District (1976):
 Councilor: Ernest B. Spangler, M.D., Greensboro
 Vice Councilor: James F. Reinhardt, M.D.,
 Greensboro
 th District (1976):
 Councilor: Verne H. Blackwelder, M.D., Lenoir
 Vice Councilor: Jack C. Evans, M.D., Lexington
 th District (1975):
 Councilor: Kenneth E. Cosgrove, M.D., Hender-
 sonville
 Vice Councilor: Otis Bentley Michael, M.D.,
 Asheville

Actions

Perhaps the most significant actions taken by the
 Society this year were the following:

In spite of five resolutions which collectively
 would have (a) changed the position of the Society
 on PSRO, (b) called for repeal of the "PSRO Act,"
 (c) mandated noncollaboration with PSRO, and (d)
 dissolved the North Carolina Medical Peer Review
 Foundation, Inc., the House instead adopted a substi-
 tute resolution as follows:

RESOLVED, that, although the North Carolina
 Medical Society strongly supports the concept of Peer
 Review, having improvement of the quality of
 medical care as its goal, we are opposed to many as-
 pects of PSRO legislation; and, be it further

RESOLVED, that in view of the fact that repeal
 of PSRO is not likely at this time, we support the
 action of the American Medical Association to have
 the law amended.

The House implemented a stand, taken last year,
 that continuing medical education be a requirement
 for membership. At this session, the House adopted
 the following requirements:

(A) That a minimum of 150 hours of continuing
 education every three years be required of each mem-

ber of the state medical society, reportable on an an-
 nual basis.

(B) That wide latitude be allowed in the manner
 in which the required time is spent. Attendance at
 scientific meetings, participation in clinical confer-
 ences, and perusal of the scientific literature are
 recognized as worthwhile forms of continuing educa-
 tion, and credit will be given for time so spent.

(C) That each physician keep and submit such
 records as will enable him to certify each year that
 he has met the minimal requirements of 50 hours.

(D) That a form for certifying compliance with
 the above requirement be included with the annual
 notice of dues sent to each physician. This form
 would then be returned along with the dues payment
 beginning with the 1976 dues.

(E) That the committee on medical education be
 requested to study and recommend methods of
 awarding credits, processing and recording replies,
 managing cases of hardship and noncompliance, and
 report their findings to the House of Delegates next
 year.

3. The North Carolina Medical Society requested
 the present and future Governors to refrain from ap-
 pointing chiropractors to the North Carolina Division
 of Health Services. The Society also went on record
 opposing any legislation which would give recogni-
 tion or accreditation to any chiropractic school,
 voiced its opposition to the granting of eligibility to
 chiropractors or other cultists for Medicare and
 Medicaid funds in the performance of their services,
 and requested the Executive Council of the North
 Carolina Medical Society to determine whether any
 legally constituted educational institution in North
 Carolina has accepted academic transfer credits from
 any chiropractic school, and express our disapproval
 of such practices if found.

4. By Constitution and By-Laws changes, a medi-
 cal student in North Carolina is eligible for student
 membership without necessarily being "an active
 member of his local Student American Medical As-
 sociation Chapter." He may become a delegate with-
 out being a member of SAMA; interns and resi-
 dents who are in training "in the United States" and
 not only "in the State of North Carolina," and who
 certify their intention, to the best of their knowledge
 at that time, to practice medicine in North Carolina,
 may now be admitted to membership in the Society
 without becoming a member of a component county
 medical society.

5. The House took a definite position on the ques-
 tion of delineation of hospital privileges. The follow-
 ing resolution was adopted:

RESOLVED, that the North Carolina Medical
 Society believes that hospital staff privileges should
 be delineated in a manner which is specific enough
 only to insure that the professional activities of each
 physician are consonant with good medical care
 practiced in his medical community; and be it further

RESOLVED, that the North Carolina Medical So-

ciety expresses to the Joint Commission on Accreditation of Hospitals and to the House of Delegates of the American Medical Association, in minute detail, its opposition to delineation of hospital staff privileges.

Society Matters

In other actions related to intrinsic Society matters, the House:

1. Endorsed an amendment to the Medical Practice Act to the effect that the Board of Medical Examiners may revoke or restrict a license to practice medicine for lack of professional competence.

2. Established separate sections on ophthalmology and on otolaryngology.

3. Instructed the North Carolina Medical Society to increase its activity in the area of public relations, legislative contact, and governmental relations.

4. Approved the annual budget estimates for 1974.

5. Approved the payment of a per diem of \$25.00 per day to the President for each day spent outside his home town on Society business, in addition to his other expenses. Also approved was reimbursement to the President-elect and the immediate Past President for their travel and living expenses, when involved in official Society functions.

6. Approved the purchase of property adjacent to the Medical Society parking area on Bloodworth Street in Raleigh.

7. Approved a By-Laws change which dissolves the Committee on Memorial Services—these duties to be assumed by the Committee on Medicine and Religion.

8. Officially encouraged members, delegates, and officers of the North Carolina Medical Society to become dues-paying members of MEDPAC, and, when

possible, to become sustaining members of MEDPAC.

Health Issues

In the area of health care and its delivery, the House:

1. Established guidelines for a medical director in a long-term care facility.

2. Made recommendations concerning the identification and treatment of cases of tuberculosis.

3. Recommended that Hemophilus influenza meningitis be made a reportable disease.

4. Called attention of the membership to an authoritative, unbiased, and lucid study on the delivery of primary medical care for Winston-Salem, North Carolina.

5. Approved the position paper "Need for More and Better Distributed Primary Care Physicians," and complimented Dr. J. Kempton Jones' committee and Dr. John McCain's subcommittee for an excellent paper.

Matters Referred to the AMA

The House referred, through the Society's delegation, the following matters to the AMA:

1. Feeling that there should be more balance between the AMA Council of Medical Education, between practicing physicians and AAMC members, the Society proposed that the Council on Medical Education consist of ten active members, of which no fewer than one, nor more than five, shall be members of a medical school faculty.

2. A resolution urging that medical specialty examining boards' articles of incorporation and bylaws restrictions for membership that are contrary to the "peer" concept be removed.

JAMES E. DAVIS, M.D., Past Speaker

Emergency Medical Services



"STATES" KEEPS AN EYE ON HIGHWAY SAFETY

**Vincent R. Gallalee, Manager
Field Service Department
National Safety Council
Chicago, Illinois**

The STATES Program is a joint effort by 37 national organizations and their counterparts in each of the 50 states, whose aim is to mobilize citizen and organizational support for the adoption and implementation of the national highway safety stan-

dards. The title is an acronym meaning, "State Through Action To Enlist Support."

This program is designed to operate in each of the 50 states assisting state government to attain compliance with the national highway safety standards. In each state there is a governor's representative, whom the governor appoints as his liaison between the federal government and those elements in the state, whether legislative or administrative, which are concerned with highway safety. In cooperation with STATES, the representative for the Governor of Illinois works closely with the pro-

se or, through a resource coordinator who is selected by him, in conjunction with the assigned field representative from one of STATES' participating organizations.

Thus, there is a team—governor's representative (G), resource coordinator (RC), and field representative (FR). This team seeks the full cooperation of all elements of STATES' participating organizations to obtain desired legislation and to achieve administrative follow-through once the legislative authority is in place. The team makes joint plans to mobilize all elements in the state, to study the needs, priorities, and build support among key officials and citizen groups. Meetings, speeches, published articles, and newsletters are designed to start the ground swell of the public voice.

Some members of the American Medical Association have been actively participating in this program at national, state, and local levels. More help, however, is needed to complete the job. Contact the STATES team in your state to find out what the needs are now. Everyone has a place in this program.

—Abstracted by GEORGE JOHNSON, JR., M.D.

From "Emergency Medicine Today," AMA Commission on Emergency Medical Services, Volume 3, No. 5, John M. Howard, M.D., Editor. Original article can be obtained from the American Medical Association, 535 North Dearborn Street, Chicago, Illinois 60610.

Correspondence

ALCOHOLISM RESEARCH IN NORTH CAROLINA

To the Editor:

In 1973 the North Carolina General Assembly created the North Carolina Alcoholism Research Authority which is authorized to receive and disburse funds through a specially created Alcoholism Research Fund. As of July 1 of this year the Fund will receive \$250,000 as a state appropriation which was voted by the 1974 legislature.

The Act creating the Alcoholism Research Authority states: "The Authority shall expend these funds on research as to the causes and effects of alcohol abuse and alcoholism and for the training of alcohol research personnel. Expenditures for the purposes specified in this section shall be made as appropriations to non-profit corporations, organizations, agencies, or institutions engaging in such research or training."

North Carolina has supported alcoholism rehabilitation services for a long time, but it is the first state to appoint a Research Authority with the power to distribute funds throughout the state which are strictly for research and research development. The Act creating the Authority recognized that North Carolina has the potential talent pool of qualified scientists to perform necessary studies and that these people need assistance to focus their efforts upon the

cause, prevention, and cure of alcoholism.

Procedures for receiving grant applications, for having these reviewed by committees of scientific consultants, and for arranging to distribute available funds are being developed by the Alcoholism Research Authority. The purpose of this letter is to publicize the existence of the Authority and to establish contact with interested scientists.

All that is necessary initially is a brief letter addressed to the undersigned which should contain the following: names and qualifications of those making inquiry; name of educational institution or scientific body with which affiliated; a brief statement indicating what alcohol-related work is presently being undertaken and what would be done with a grant from the Alcoholism Research Authority; and, a rough estimate as to the amount of money for which application is contemplated. All such letters of inquiry will receive a reply, and those proposals which seem most promising will be studied in more detail by our sending out official invitations to submit a grant application.

JOHN A. EWING, M.D.
Executive Secretary
North Carolina Alcoholism Research Authority
623 East Franklin Street
Chapel Hill, North Carolina 27514

Committees and Organizations

COMMITTEE ON MEDICARE

Greensboro, April 6, 1974

The committee discussed the recommendation of the Council on Review and Development that the Medicare Committee be dropped and its function be added to the Insurance Industry Committee.

Although a formal recommendation was not made, the consensus of the members present was the following: that the Committee on Medicare should continue as a separate committee and should not be merged with the Insurance Industry Committee.

WILLIAM T. RABY, M.D., *Chairman*

COMMITTEE ON PUBLIC RELATIONS

Raleigh, April 10, 1974

The committee recommended that:

(1) Dr. Elizabeth P. Kanof's pamphlet "How to be a Good Doctor's Good Patient" be distributed to the membership as an enclosure with the "Public Relations Bulletin"; that an appropriately marked record be included for physicians' orders and comments, and that; authorized orders for up to 10 pamphlets per physician be provided on a gratis basis, and a nominal charge be made for orders for more than 100. (2) A member of the Headquarters staff be assigned to devote most of his time to the North Carolina Medical Society's public relations programs.

JOHN L. MCCAIN, M.D., *Chairman*

TUCKER HOSPITAL, Inc.

212 West Franklin Street

RICHMOND, VIRGINIA

A private hospital for diagnosis and treatment of psychiatric and neurological disorders. Hospital and out-patient services.

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JAMES ASA SHIELD, M.D.

JAMES ASA SHIELD, JR., M.D.

CATHERINE T. RAY, M.D.

WEIR M. TUCKER, M.D.

GEORGE S. FULTZ, JR., M.D.

GRAENUM R. SCHIFF, M.D.

Committee and Commission Appointments 1974-1975

NOTE: The Committees listed herein have been authorized by President Frank R. Reynolds, M.D., and/or as required under the *Constitution and Bylaws*.

Particular note should be taken of the authorization of the HOUSE OF DELEGATES of a Commission form of organizational activity and that all Committees, excepting *COMMITTEE ON NOMINATIONS AND MEDIATION COMMITTEE* are segregated under the respective Commission in which the function of the Committee logically rests. This will tend to eliminate overlapping and duplication in activity programs and result in coordination of the work of the Society in a manner to lessen the work of the delegates in the Annual Meeting of the HOUSE OF DELEGATES.

The President, Secretary and Executive Director of the Society are ex officio members of all Committees and, along with the Commission Chairman, should receive notice of meetings, agenda and minutes of committee meetings during the activity year.

Superior figures (e.g. 21) indicate the component County Society from which the member emanates, as in the Membership list of the *ROSTER*.)

I. ADMINISTRATION COMMISSION

A. Hewitt Rose, Jr., M.D., *Chairman*
3801 Computer Dr., Raleigh 27609

*Committee
Listing*

Finance, Committee on (I-1)

No. 22

T. Tilghman Herring, M.D., *Chairman*
Wilson Clinic, Wilson 27893

Personnel & Headquarters Operation, Com. on (I-2)

No. 41

A. Hewitt Rose, Jr., M.D., *Chairman*
3801 Computer Dr., Raleigh 27609

Insurance, Com. on Professional (I-3)

No. 45

John C. Burwell, Jr., M.D., *Chairman*
1026 Professional Village, Greensboro 27401

Retirement Savings Plan Committee (I-4)

No. 50

Jesse Caldwell, Jr., M.D., *Chairman*
114 W. Third St., Gastonia 28052

4. Cancer, Committee on (II-4)

No. 9

Rose Pully, M.D., *Chairman*
1007½ N. College St., Kinston 28501

5. Constitution & Bylaws, Com. on (II-5)

No. 14

Louis deS. Shaffner, M.D., *Chairman*
Bowman Gray, Winston-Salem 27103

6. Medical Education, Com. on (II-6)

No. 31

Albert L. Chasson, M.D., *Chairman*
Rex Hospital, Raleigh 27603

7. Medical Students, Com. Adv. to (II-7)

No. 33

William P. J. Peete, M.D., *Chairman*
Duke Univ. Med. Ctr., Durham 27710

8. Relative Value Study, Com. on (II-8)

No. 49

Arthur E. Davis, Jr., M.D., *Chairman*
Rex Hospital, Raleigh 27603

9. Traffic Safety, Com. on (II-9)

No. 52

Edgar T. Beddingfield, Jr., M.D., *Chairman*
Wilson Clinic, Wilson 27893

II. ADVISORY AND STUDY COMMISSION

Roy S. Bigham, Jr., M.D., *Chairman*
1708 E. Fourth St., Charlotte 28204

Allied Health Professionals, Com. on (II-1)

No. 1

W. B. McCutcheon, Jr., M.D., *Chairman*
1830 Hillandale Rd., Durham 27705

Anesthesia Study, Com. on (II-2)

No. 2

Albert Arthur Bechtoldt, Jr., M.D., *Chairman*
UNC Sch. of Med., Chapel Hill 27514

Auxiliary, Committee Advisory to (II-3)

No. 6

Gloria F. Graham, M.D., *Chairman*
1010 W. Nash St., Wilson 27893

III. ANNUAL CONVENTION COMMISSION

Josephine E. Newell, M.D., *Chairman*
P. O. Box 68, Bailey 27807

1. Arrangements, Committee on (III-1)

No. 3

E. Harvey Estes, Jr., M.D., *Chairman*
Duke Univ. Med. Ctr., Durham 27710

2. Audio-Visual Programs, Com. on (III-2)

No. 5

George Pat Henderson, Jr., M.D., *Chairman*
115 Highland Ave., Southern Pines 28374

3. Awards, Committee on Scientific (III-3)

No. 7

David S. Citron, M.D., *Chairman*
Box 2554, Charlotte Mem. Hosp., Charlotte 28201

4. **Credentials, Com. on (of House of Delegates) (III-4)** **No. 15**
John A. Payne, II, M.D., *Chairman*
Box 157, Sunbury 27979
5. **Exhibits, Committee on (III-5)** **No. 20**
Josephine E. Newell, M.D., *Chairman*
Box 68, Bailey 27807
6. **Programs for General Sessions, Com. on (III-6)** **No. 46**
T. Reginald Harris, M.D., *Chairman*
808 N. DeKalb St., Shelby 28150

IV. PROFESSIONAL SERVICE COMMISSION

Bernard A. Wansker, M.D., *Chairman*
1900 Randolph Rd., Charlotte 28207

1. **Blue Shield, Committee on (IV-1)** **No. 8**
Leon W. Robertson, M.D., *Chairman*
107 Med. Arts Mall, Rocky Mount 27801
2. **Crippled Children's Program, Com. Advisory to (IV-2)** **No. 16**
Robert Underdal, M.D., *Chairman*
1900 S. Hawthorne Rd., Winston-Salem 27103
3. **Hospital & Professional Relations and Liaison to North Carolina Hospital Association (IV-3)** **No. 23**
Joe M. Van Hoy, M.D., *Chairman*
3535 Randolph Rd., Charlotte 28211
4. **Industrial Commission, Com. to Work with N.C. (IV-4)** **No. 24**
Ernest B. Spangler, M.D., *Chairman*
3811 Henderson Road, Greensboro 27410
5. **Insurance Industry Committee (IV-5)** **No. 25**
Charles H. Duckett, M.D., *Chairman*
Midway Med. Clinic, Canton 28716
6. **Physical & Vocational Rehabilitation, Com. on (IV-6)** **No. 43**
Edwin H. Martinat, M.D., *Chairman*
3333 Silas Creek Parkway, Winston-Salem 27103
7. **ad hoc Study Committee on Fees (IV-7)** **No. 53**
T. Reginald Harris, M.D., *Chairman*
808 N. DeKalb St., Shelby 28150

V. PUBLIC RELATIONS COMMISSION

John L. McCain, M.D., *Chairman*
Wilson Clinic, Wilson 27893

1. **Association of Professions, Com. on (V-1)** **No. 4**
Thomas G. Thurston, M.D., *Chairman*
512 Mocksville Ave., Salisbury 28144
2. **Community Medical Care, Com. on (V-2)** **No. 12**
J. Kempton Jones, M.D., *Chairman*
1001 S. Hamilton Rd., Chapel Hill 27514
3. **Disaster and Emergency Medical Care, Com. on (V-3)** **No. 18**
George A. Watson, M.D., *Chairman*
4023 Bristol Rd., Durham 27707
4. **Eye Care & Eye Bank, Com. on (V-4)** **No. 21**
Ernest W. Larkin, Jr., M.D., *Chairman*
211 N. Market St., Washington 27889

5. **Legislation, Com. on (V-5)** **No. 1**
H. David Bruton, M.D., *Chairman*
Town Center, Southern Pines 28387
6. **Medical-Legal Committee (V-6)** **No. 4**
Julius Howell, M.D., *Chairman*
Bowman Gray, Winston-Salem 27103
7. **North Carolina Pharmaceutical Association, Com. Liaison to (V-7)** **No. 6**
Charles W. Byrd, M.D., *Chairman*
Box 708, Dunn 28334
8. **Public Relations, Committee on (V-8)** **No. 1**
John L. McCain, M.D., *Chairman*
Wilson Clinic, Wilson 27893

VI. PUBLIC SERVICE COMMISSION

Philip G. Nelson, M.D., *Chairman*
Medical Pavilion, Greenville 27834

1. **Child Health and Infectious Diseases, Com. on (VI-1)** **No. 1**
William L. London, M.D., *Chairman*
306 S. Gregson St., Durham 27701
2. **Chronic Illness, TB and Heart Disease, Com. on (VI-2)** **No. 2**
Dirk Verhoeff, M.D., *Chairman*
Huntersville Hosp., Huntersville 28078
3. **Drug Abuse, Committee on (VI-3)** **No. 3**
Wm. J. K. Rockwell, M.D., *Chairman*
Duke Univ. Med. Ctr., Durham 27710
4. **Marriage Counseling & Family Life Education, Com. on (VI-4)** **No. 4**
John B. Reckless, M.D., *Chairman*
5504 Durham-Chapel Hill Blvd., Durham 27707
5. **Maternal Health, Committee on (VI-5)** **No. 5**
W. Joseph May, M.D., *Chairman*
121 Prof. Bldg., Winston-Salem 27103
6. **Medical Aspects of Sports, Com. on (VI-6)** **No. 6**
Frank C. Wilson, Jr., M.D., *Chairman*
N. C. Mem. Hosp., Chapel Hill 27514
7. **Medicine and Religion, Com. on (VI-7)** **No. 7**
Jack W. Wilkerson, M.D., *Chairman*
Greenville Clinic, Greenville 27834
8. **Mental Health, Committee on (VI-8)** **No. 8**
Philip G. Nelson, M.D., *Chairman*
Medical Pavilion, Greenville 27834
9. **Occupational & Environmental Health, Com. on (VI-9)** **No. 9**
Harold R. Imbus, M.D., *Chairman*
P. O. Box 21207, Greensboro 27420

VII. DEVELOPING GOVERNMENT HEALTH PROGRAMS COMMISSION

John A. McLeod, Jr., M.D., *Chairman*
Memorial Mission Hosp., Asheville 28801

1. **Comprehensive Health Service Planning, Com. on (VII-1)** **No. 1**
Robert C. Moffatt, M.D., *Chairman*
309 Doctors' Bldg., Asheville 28801

- Medicare, Committee on (VII-2)** **No. 34**
William T. Raby, M.D., *Chairman*
1012 Kings Drive, Charlotte 28207
- Peer Review, Committee on (VII-3)** **No. 40**
M. Frank Sohmer, Jr., M.D., *Chairman*
Prof. Bldg., Winston-Salem 27103
- Social Service Programs, Com. on (including Medicaid) (VII-4)** **No. 51**
James S. Mitchener, M.D., *Chairman*
Box 1599, Laurinburg 28352
- Committees Not Assigned to A Commission**
- DIATION, COMMITTEE ON** **No. 29**
Edgar T. Beddingfield, Jr., M.D., *Chairman*
Wilson Clinic, Wilson 27893
George G. Gilbert, M.D., *Secretary*
Doctors Park, Asheville 28801
- MINATIONS, COMMITTEE ON** **No. 37**
Elliott Dixon, M.D., *Chairman*
15 E. 2nd St., Ayden 28513
- COUNCIL ON REVIEW & DEVELOPMENT** **No. 17**
John Glasson, M.D., *Chairman*
406 S. Gregson St., Durham 27701
- Committee on Allied Health Professionals (6) II-1**
W. B. McCutcheon, Jr., M.D.³² *Chairman*
1830 Hillandale Road, Durham 27705
J. Samuel Holbrook, M.D.⁴⁹
Davis Hospital, Statesville 28677
Frederick C. Hubbard, M.D.⁹⁷
Box 39, N. Wilkesboro 28659
Oliver Ray Hunt, M.D.⁶⁵
1607 Doctors Circle, Wilmington 28401
Wayne B. Venters, M.D.⁶⁷
200 Doctor Dr., Suite J, Jacksonville 28540
Donald K. Wallace, M.D.⁶³
945 Sandavis Rd., Southern Pines 28387
- Committee on Anesthesia Study (6) II-2**
Albert Arthur Bechtoldt, Jr., M.D.³² *Chairman*
UNC School of Medicine, Chapel Hill 27514
Lewis J. Gaskins, M.D.⁹²
Rex Hosp., Dept. of Anes., Raleigh 27603
C. T. Harris, M.D.⁶⁰
401 Fesbrook Court, Charlotte 28211
John R. Hoskins, III, M.D.¹¹
202 Doctors Bldg., Asheville 28801
Albert R. Howard, M.D.¹
506 N. Gurney St., Burlington 27215
Bill Joe Swan, M.D.¹³
776 Williamsburg Dr., Concord 28025
- Committee on Arrangements (3) (6 Consultants) III-1**
E. Harvey Estes, Jr., M.D.³² *Chairman*
Duke University Med. Ctr., Durham 27710
John Glasson, M.D.³²
306 S. Gregson St., Durham 27701
H. David Bruton, M.D.⁶³
Town Center, Southern Pines 28387
- Consultants:**
Chalmers R. Carr, M.D.⁶⁰ (Speaker-House of Delegates)
1822 Brunswick Ave., Charlotte 28207
- David S. Citron, M.D.⁶⁰ (Chrm.-Com. on Awards)
Box 2554, Charlotte 28201
T. Reginald Harris, M.D.²³ (Chrm.-Com. on General Sessions Programs)
808 N. DeKalb St., Shelby 28150
Michael Pishko, M.D.⁶³
Pinchurst Surgical Clinic, Pinchurst 28374
William H. Romm, M.D.⁷⁰
Box 26, Moyock 27958
Mrs. A. J. Crutchfield (Auxiliary)
Quail Hollow Rd., Rt. 2, Clemmons 27102
- 4. Committee on Association of Professions (6) (6 Consultants) V-1**
Thomas G. Thurston, M.D.⁸⁰ *Chairman*
512 Mocksville Ave., Salisbury 28144
John C. Hamrick, M.D.²³
Box 668, Shelby 28150
Edward K. Isbey, Jr., M.D.¹¹
3-C Doctors Park, Asheville 28801
John R. Kernodle, M.D.¹
Kernodle Clinic, Burlington 27215
John S. Rhodes, M.D.⁹²
1300 St. Mary's St., Raleigh 27605
George G. Gilbert, M.D.¹¹
1 Doctors Park, Asheville 28801
- Consultants:**
H. Fleming Fuller, M.D.⁵⁴
Kinston Clinic, Box 268, Kinston 28501
Thomas P. Nash, II, M.D.⁷⁰
1142 N. Road St., Elizabeth City 27909
Edward Leon Roberson, M.D.³³
Tarboro Clinic, Tarboro 27886
Richard V. Surgnier, M.D.¹⁸
419 2nd St., NW, Hickory 28601
Walter T. Tice, M.D.⁴¹
624 Quaker Lane, High Point 27262
John L. Hazelhurst, M.D.¹¹
108 Doctors Bldg., Asheville 28801
- 5. Committee on Audio-Visual Programs (7) III-2**
George Pat Henderson, M.D.⁶³ *Chairman*
115 Highland Rd., Southern Pines 28387
Paul McB. Abernethy, M.D.¹
P. O. Box 2480, Burlington 27215
Thornton R. Cleek, M.D.⁷⁶
379 S. Cox St., Asheboro 27203
Jack C. Evans, M.D.²⁹
244 Fairview Dr., Lexington 27292
John C. Grier, Jr., M.D.⁶³
Box 791, Pinchurst 28374
John L. Monroe, M.D.⁶³
Pinchurst Surgical Clinic, Pinchurst 28374
J. Benjamin Warren, M.D.²⁵
Box 1465, New Bern 28560
- 6. Committee Advisory to Auxiliary (6) (1 Consultant) II-3**
Gloria F. Graham, MD.⁹⁸ *Chairman*
1010 W. Nash St., Wilson 27893
Robert J. Andrews, M.D.⁶⁵
5221 Wrightsville Ave., Wilmington 28401
Bruce B. Blackmon, M.D.⁴³
P. O. Box 8, Buies Creek 27506
A. J. Crutchfield, M.D.³⁴
93 Prof. Bldg., Winston-Salem 27103

Rose Pulley, M.D.⁵⁴
1007 1/2 N. College St., Kinston 28501
Philip E. Russell, M.D.¹¹
204 Doctors Bldg., Asheville 28801

Consultant:

Mrs. William Corpening (AMA-ERF Auxiliary Chairman)
Box 200, Granite Falls 28630

7. Committee on Scientific Awards (9) (3-yr Terms)

III-3

David S. Citron, M.D.⁶⁰ (1975), *Chairman*
Box 2554, Charlotte Mem. Hosp., Charlotte 28201
John A. Brabson, M.D.⁶⁰ (1976)
225 Hawthorne Lane, Charlotte 28204
Frank M. Mauney, Jr., M.D.¹¹ (1976)
Suite 412, Doctors Park, Asheville 28801
Emery C. Miller, M.D.⁴¹ (1977)
Bowman Gray, Winston-Salem 27103
James Fidler, M.D.⁶⁵ (1977)
1919 S. 16th St., Wilmington 28401
Ted D. Scurletis, M.D.⁹² (1976)
1301 Hunting Ridge Rd., Raleigh 27609
John K. Williford, M.D.⁴⁴ (1975)
Box 278, Lillington 27546
Thomas Wood, III, M.D.⁴¹ (1975)
624 Quaker Lane, Suite 116, High Point 27262
Robert Smith, M.D.³² (1977)
UNC Sch. Med., Chapel Hill 27514

8. Committee on Blue Shield (31) (10 Consultants) IV-1

Leon W. Robertson, M.D.³³ (EP) (IV) 1975, *Chairman*
107 Med. Arts Mall, Rocky Mount 27801
William B. McCutcheon, Jr., M.D.³² (S) (VI) 1975,
Vice-Chairman
1830 Hillandale Rd., Durham 27705
Arthur F. Davis, Jr., M.D.⁹² (PTH) (VI) 1976
Rex Hospital, Raleigh 27603
Melvin F. Fyerman, M.D.¹⁵ (PH) (VII) 1977
Box 636, Lincolnton 28092
William W. Farley, M.D.⁹² (Pd) (VI) 1976
1300 St. Mary's St., Raleigh 27605
Joe Thomas Fox, Jr., M.D.⁶⁰ (P) (VII) 1977
1900 Randolph Rd., Charlotte 28207
Robert M. Gay, M.D.¹¹ (PTH) (VIII) 1977
P. O. Box 13227, Moses Cone Hosp., Greensboro 27405
Gloria F. Graham, M.D.⁹⁵ (D) (IV) 1977
1010 Nash St., Wilson 27893
Lawrence B. Haynes, M.D.⁹² (AN) (VI) 1975
1205 Kershaw Dr., Raleigh 27609
Charles L. Herring, M.D.⁵⁴ (I) (II) 1976
310 Glenwood Ave., Kinston 28501
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(OTO) 19

(To be filled by E. C. 9/29/74)

(Oph) 19

(To be filled by E. C. 9/29/74)

(NS) 19

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15. Committee on Credentials (Of Delegates to House of Delegates) (3) III-4

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16. Advisory Committee to the Crippled Children's Program (7) IV-2

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17. Council on Review & Development (10) (4-Ex Officio with Vote)

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Ex Officio With Vote:

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 James E. Davis, M.D.⁹² (President-Elect)
 1200 Broad St., Durham 27705
 George G. Gilbert, M.D.¹¹ (Past President)
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 E. Harvey Estes, Jr., M.D.³² (Secretary)
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18. Committee on Disaster & Emergency Medical Care (12) V-3

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23. Committee on Hospital & Professional Relations & Liaison to North Carolina Hospital Association (10) IV-3

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25. Insurance Industry Committee (28) IV-5

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26. Committee on Legislation (3 Plus President and Secretary) (17 Consultants) V-5

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27. Committee on Marriage Counseling & Family Life Education (11) VI-4

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 Luther M. Talbert, M.D.³²
 N. C. Mem. Hosp., Chapel Hill 27514

2 Committee on Maternal Health (14) VI-5 (6 yr. Terms)

W. Joseph May, M.D.³⁴ (8th) (1976) *Chairman and Secretary*
 300 S. Hawthorne Rd., Winston-Salem 27103
 Stephen G. Anderson, M.D.³⁴ (1977)
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 Glenn E. Best, M.D.⁸² (3rd) (1978)
 104 Main St., Clinton 28328
 Clifford C. Byrum, M.D.⁹² (6th) (1979)
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 Jesse Caldwell, M.D.³⁶ (7th) (1979)
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 Edgar C. Garber, Jr., M.D.²⁶ (5th) (1977)
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 William A. Hoggard, Jr., M.D.⁷⁰ (1st) (1977)
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 Ann H. Huizenga, M.D.⁹² (1978)
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 John A. Kirkland, M.D.⁹⁸ (4th) (1976)
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 Robert L. Rogers, M.D.¹⁴ (9th) (1976)
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 Fletcher S. Sluder, M.D.¹¹ (10th) (1975)
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2 Mediation Committee (5) VIII (Five Immediate Past Presidents)

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 Louis deS. Shaffner, M.D.³⁴
 Bowman Gray, Winston-Salem 27103
 Charles W. Styron, M.D.⁹²
 615 St. Mary's St., Raleigh 27605
 John Glasson, M.D.³²
 306 S. Gregson St., Durham 27701

3 Committee on Medical Aspects of Sports (15) (3 Consultants) VI-6

Frank C. Wilson, Jr., M.D.³² *Chairman*
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 P. O. Drawer 1694, New Bern 28560
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 Al Proctor, N. C. Dept. Public Instruction, Sports
 Medicine Div., Education Bldg., Raleigh 27605
 Raymond K. Rhodes, Director of Athletics State Dept.
 of Public Instruction, Raleigh 27605

31. Committee on Medical Education (21) (4 Consultants) (5-yr. Terms) II-6

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Mr. Michael E. Wayda, Audio-Visual Education
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32. Medical-Legal Committee (9) V-6

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33. Committee Advisory to Medical Students (6) II-7

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34. Committee on Medicare (10) VII-2

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35. Committee on Medicine & Religion (9) (6 Consultants) VI-7

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Rev. Samuel Wiley
Box 6637, College Sta., Durham 27708
Rev. Richard R. Young
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36. Committee on Mental Health (28) VI-8

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38. Advisor to North Carolina Association of Medical Assistants (I)

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39. Committee on Occupational & Environmental Health (15) (2 Consultants) VI-9

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State Board of Health, Box 2091, Raleigh 27602

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40. Committee on Peer Review (21) VII-3

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**41. Committee on Personnel & Headquarters Operations
 (5) I-3**

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Ex Officio:

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 E. Harvey Estes, Jr., M.D.³² (Secretary)
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 George G. Gilbert, M.D.¹¹ (Past President)
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**42. Committee Liaison to North Carolina Pharmaceutical
 Association (6) (2 Consultants) V-7**

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**43. Committee on Physical & Vocational Rehabilitation
 (9) IV-6**

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44. Medical Society Consultant on Podiatry (1)

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45. Committee on Professional Insurance (19) I-3

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Committee on Programs for General Sessions (7) III-6

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Committee on Public Relations (4) (8 Consultants) V-8

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Committee on Relative Value Study (16) II-8

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202 Doctors Bldg., Asheville 28801
- David H. Jones, M.D.⁹² (OPH)
1300 St. Mary's St., Raleigh 27605
- O. Hunter Jones, M.D.⁶⁰ (OB-G)
1012 Kings Dr., Charlotte 28207

- Riley M. Jordan, M.D.¹⁷ (GP)
Box 276, Raeford 28376
- Curtis R. Lashley, M.D.¹¹ (Admin)
Box 20727, Pilot Life, Greensboro 27401
- William L. London, M.D.³² (Pd)
306 S. Gregson St., Durham 27701
- Hoke S. Nash, Jr., M.D.⁶⁰ (Otol)
1600 E. Third St., Charlotte 28204
- Ernest B. Spangler, M.D.¹³ (R)
Drawer X3, Greensboro 27402
- Walter T. Tice, M.D.¹¹ (I)
624 Quaker Lane, High Point 27262
- Bernard A. Wansker, M.D.⁶⁰ (D)
Suite 400, Metroview Bldg.
1900 Randolph Rd., Charlotte 28207
- Roston M. Williamson, M.D.³² (OB-G)
306 S. Gregson St., Durham 27701
- Isaac C. Wright, M.D.⁹² (I)
119 N. Boylan Ave., Raleigh 27603

50. Retirement Savings Plan Committee (6) I-4

- Jesse Caldwell, Jr., M.D.³⁶ (1975) *Chairman*
114 W. Third St., Gastonia 28052
- Vernon L. Andrews, M.D.⁶² (1976)
Box 8, Mount Gilead 27306
- William F. Hollister, M.D.⁶³ (1975)
Box 2000, Pinchurst 28374
- George W. James, M.D.³⁴ (1977)
205 S. Hawthorne Rd., Winston-Salem 27103
(to be filled by E. C. 1975 (9/29/74))
- A. Hewitt Rose, Jr., M.D.⁹² (1977)
3801 Computer Dr., Raleigh 27609
- Robert W. Williams, M.D.⁶⁵ (1976)
3208 Oleander Dr., Wilmington 28401

51. Committee on Social Services Programs (Including Medicaid) (18) VII-4

- James S. Mitchener, M.D.⁸³ *Chairman*
Box 1599, Laurinburg 28352
- Edgar T. Beddingfield, Jr., M.D.⁹⁸
Wilson Clinic, Wilson 27893
- Bruce B. Blackmon, M.D.⁴³
P. O. Box 8, Buies Creek 27506
- J. Elliott Dixon, M.D.⁷⁴
215 E. Second St., Ayden 28513
- E. Stephen Edwards, M.D.⁹²
1300 St. Mary's St., Raleigh 27605
- Albin W. Johnson, M.D.⁹²
1300 St. Mary's St., Raleigh 27605
- Ralph V. Kidd, M.D.⁶⁰
1928 Randolph Rd., Charlotte 28207
- Thomas W. Kitchin, Jr., M.D.⁶⁷
510 College St., Jacksonville 28540
- William T. MacLauchlin, M.D.¹⁸
Box 774, Conover 28613
- Tom N. Massey, M.D.⁶⁰
217 Travis Ave., Charlotte 28204
- Campbell White MacMillan, M.D.³²
N. C. Mem. Hosp., Chapel Hill 27514
- Otis B. Michael, M.D.¹¹
208 Doctors Bldg., Asheville 28801
- Leslie M. Morris, M.D.³⁶
Box 1495, Gastonia 28052
- Charles P. Nicholson, M.D.¹⁶
3108 Arendell St., Morehead City 28557

George W. Paschal, Jr., M.D.⁹²
 1110 Wake Forest Rd., Raleigh 27604
 Emery L. Rann, M.D.⁶⁰
 1001 Beatties Ford Rd., Charlotte 28204
 Donald B. Reibel, M.D.⁹²
 P. O. Box 10707, Raleigh 27605
 Russell L. Smith, M.D.³⁴
 114 E. 3rd St., Winston-Salem 27101

52. Committee on Traffic Safety (12) (3 Consultants) II-9

E. T. Beddingfield, Jr., M.D.⁹⁸ *Chairman*
 Wilson Clinic, Wilson 27893
 Vernon L. Andrews, M.D.⁶²
 Box 8, Mt. Gilead 27306
 Allan B. Coggeshall, M.D.⁴¹
 P. O. Box 10186, Greensboro 27404
 Daniel S. Currie, M.D.²⁶
 111 Bradford Ave., Fayetteville 28301
 William J. DeMaria, M.D.³²
 1126 Woodburn Rd., Durham 27705
 Harold D. Green, M.D.³⁴
 Bowman Gray, Winston-Salem 27103
 Jesse H. Meredith, M.D.³¹
 Bowman Gray, Winston-Salem 27103
 John W. Morris, M.D.¹⁶
 2410 Evans St., Morehead City 28557
 James F. Newsome, M.D.³²
 N. C. Mem. Hosp., Chapel Hill 27514
 Fred G. Patterson, M.D.³²
 1001 S. Hamilton Rd., Chapel Hill 27514

Jack M. Rogers, M.D.³⁴
 Bowman Gray, Winston-Salem 27103
 Albert Stewart, Jr., M.D.²⁶
 114 Broadfoot Ave., Fayetteville 28305

Consultants:

Col. Charles Speed (Ret.)
 Box D-25801, Raleigh
 Mr. Douglas Wooten
 Dept. Transportation & Highway Safety
 Raleigh 27610
 Dr. Verne Roberts
 State Services Dept., National Driving Ctr.,
 255 Engineering Annex, Duke Univ., Durham 27705

53. ad hoc Study Committee on Fees (6) IV-7

T. Reginald Harris, M.D.²³ *Chairman*
 808 N. Dekalb St., Shelby 28150
 J. Benjamin Warren, M.D.²⁵
 Box 1465, New Bern 28560
 Bernard A. Wansker, M.D.⁶⁰
 1900 Randolph Rd., Suite 400, Charlotte 28207
 William L. London, M.D.³²
 306 S. Gregson St., Durham 27701
 Albert Stewart, Jr., M.D.²⁶
 114 Broadfoot Ave., Fayetteville 28305
 Ira M. Hardy, II, M.D.⁷⁴
 1709 W. Sixth St., Greenville 27834

Bulletin Board

NEW MEMBERS of the State Society

anin, Ms. Patricia Anne (Student), 421 Chateau Apts., Chapel Hill 27514
 Anza, Romeo Briones, MD (GS), 106 Stewart St., Southport 28461
 Atti, Muhammad Arshad, MD (IM), 3111 Maplewood Ave., Winston-Salem 27103
 Cie, James Alexander, MD (TS), Ivy & W. 3rd St.,iler City 27344
 Ey, James Kearney, MD (DR), 1416 Brookgreen Ave.,atesville 28677
 Gyn, Anna Bauhofer, MD (AN), 117 Pinetree Rd., Salisbury 28144
 ndel, Clifford Craig, MD (Intern-Resident), 608 Churchill Dr., Chapel Hill 27514
 nan, Wm. Henry, Jr., MD (ORS), 194 Summer Hill Rd., Fayetteville 28303
 is, Wm. Walter, III, MD (GP), Rt. 1, Box 92-14, wansboro 28584
 er, Leonard M., MD (IM), Connetsee Falls, Rt. 1, revard 28712
 hian, George Gene, MD (FP), Coach Road, Reidsville
 ury, Roswell Tempest, MD (GS), 104 Perth Court, ary 27511
 ns, James Francis, MD (GS), Chestnut Dr., Box 446, lowing Rock 28605
 ri, Anthony John, MD (PTH), Morehead Mem. Hosp., den 27288
 us, Simon, MD (Former Member), Box 37, Cherry Hospital, Goldsboro 27530
 walla, Sorab Pestonji, MD (GS), 512 Raymond St., Mocksville 27028
 anteson, Rodney Allen, MD (ORS), 1226 W. Kenan t., Wilson 27893
 rrisson, Robert Lord, MD (AN), 327 Robert E. Lee Dr., Wilmington 28401
 h, Carl Wm., MD (R), P. O. Box 368, Eden 27288
 ness, John Lavon, MD (OBG), Fletcher Medical Center, Fletcher
 row, Barry Seymour, MD (P), Rt. 3, Box 97, Zebulon 7397
 nn, Rayford Edwin, MD (GP), 117 W. Pennsylvania Ave., Bessemer City
 ldon, Frank Chadwick, MD (GS), 310 N. Smithwick t., Williamston 27892
 lman, Louis Cromwell, MD (GP), 2860 Holyoke Place, Winston-Salem 27103
 mpson, John Albert, Jr., MD (D), 1900 Randolph Rd., Charlotte 28207
 itley, Robert Riley, MD (GP), 907 Country Club Dr., eidsville
 od, Everet Hardenbergh, MD (OPH), 205 Park View Jr., Brevard 28715
 ung, Charles Gibson, MD (IND), Fieldcrest Mills, Eden 7288

WHAT? WHEN? WHERE?

In Continuing Education July 1974

("Place" and "sponsor" are listed only where these differ from the place and group or institution listed under "for information.")

In North Carolina July 29-August 2

Second Annual Beach Workshop: Selected Topics in General Internal Medicine
 Sponsors: Bowman Gray, Duke and UNC Schools of Medicine, in conjunction with the Medical University of South Carolina
 Place: St. Johns Inn, Myrtle Beach, South Carolina
 Fee: \$100
 For Information: Emery C. Miller, M.D., Associate Dean for Continuing Education, Bowman Gray School of Medicine, Winston-Salem 27103

September 6-7

Annual Meeting of the North Carolina Chapter of the American Academy of Pediatrics and The North Carolina Pediatric Society
 Place: Pinehurst Hotel and Country Club
 For Information: Mrs. John McLain, Executive Secretary, 3209 Rugby Road, Durham 27707

September 6-7

Symposium on Arthritis
 Place: Babcock Auditorium
 Fee: \$30.00
 For Information: Emery C. Miller, M.D., Associate Dean for Continuing Education, Bowman Gray School of Medicine, Winston-Salem 27103

September 13

Pathology and Treatment of Conditions Affecting the Knee Joint
 This is a one day course designed for rehabilitation nurses, insurance carriers and members of the Industrial Accident Commission of N. C.
 Sponsor: Division of Orthopaedic Surgery, Department of Surgery
 For Information: Frank H. Bassett, III, M.D., Box 2919, Duke University Medical Center, Durham 27710

September 18-19

19th Annual Angus M. McBryde Perinatal Symposium
 Fee: \$50.00
 For Information: George Brumley, M.D., Division of Perinatal Medicine, P. O. Box 2911, Duke University Medical Center, Durham 27710

September 19-21

Topics in Internal Medicine, the Fourth Annual Seminar in Medicine
 Place: Babcock Auditorium
 Fee: \$75.00
 For Information: Emery C. Miller, M.D., Associate Dean

Cancer Center (CR-III), which is scheduled to be completed by 1977.

A native of Philadelphia, Abramson received his B.S. degree from Ursinus College in Collegeville, Pa., and M.D. degree from Temple University Medical School in Philadelphia.

He served a rotating internship at Mount Zion Hospital in San Francisco, and received special training in psychiatry at Boston University Medical Center and in therapeutic radiology at Duke from 1967-1970.

Following training, Abramson was in private practice in therapeutic radiology for one year at Alta Bates Hospital in Berkeley, Calif.

He returned to Duke in 1971, as assistant professor of radiology.

* * *

The National Multiple Sclerosis Society has awarded a two-year postdoctoral fellowship grant of \$18,350 to Dr. Ronald Charles Waldbillig.

Waldbillig will work under the supervision of Dr. J. David Robertson, professor and chairman of the Department of Anatomy.

News Notes from the—

BOWMAN GRAY SCHOOL OF MEDICINE WAKE FOREST UNIVERSITY

The Bowman Gray School of Medicine has received an \$805,000 grant from the National Heart and Lung Institute for research into lung diseases and the lung's defenses against those diseases.

The project, which is supported for a five-year period, will involve faculty members from several departments and graduate students in the Department of Microbiology. Some medical students will also be involved.

Dr. Quentin N. Myrvik, professor and chairman of the Department of Microbiology, is director of the research effort. Dr. Joseph E. Johnson, professor and chairman of the Department of Medicine, is the co-director.

* * *

The Rev. Frank R. Campbell of Statesville has been elected chairman of the Joint Medical Center Administrative Board of the medical school and hospital.

He succeeds Francis E. Garvin of Wilkesboro, the first chairman of the administrative board.

The board, established in February, has eight trustees from Wake Forest University, eight trustees from the hospital and a member of the professional staff. It was delegated the responsibility for overall supervision of the medical center.

Randomycin (methacycline HCl)

CONTRAINDICATIONS

Hypersensitivity to any of the tetracyclines. **WARNINGS** Tetracycline usage during tooth development (last half of pregnancy to 8 years) may cause permanent tooth discoloration (yellow-gray-brown), which is common during long-term use but has occurred after repeated short-term courses. Enamel hypoplasia has also been reported. **Tetracyclines should not be used in this group unless other drugs are not likely to be effective or are contraindicated.**

Usage in pregnancy (See above **WARNINGS** about use during tooth development). Animal studies indicate that tetracyclines cross the placenta and can be toxic to the developing fetus (often related to retardation of skeletal development). Embryotoxicity also been noted in animals treated early in pregnancy.

Usage in newborns, infants, and children (See above **WARNINGS** about use during tooth development).

All tetracyclines form a stable calcium complex in any bone-forming tissue. A decrease in fetal bone growth rate observed in premature given oral tetracycline 25 mg/kg every 6 hours was reversible when drug was discontinued.

Tetracyclines are present in milk of lactating women taking tetracyclines. To avoid excess systemic accumulation and liver toxicity in patients with impaired liver function, reduce usual total dosage and if therapy is prolonged, consider serum level determinations of drug. The anti-anabolic action of tetracyclines may increase BUN. V not a problem in normal renal function, in patients with significantly impaired renal function, higher tetracycline serum levels may lead to azotemia, hyperphosphatemia, and acidosis.

Photosensitivity manifested by exaggerated sunburn reaction has occurred with tetracyclines. Patients apt to be exposed to direct sunlight or ultraviolet light should be advised, and treatment should be discontinued at first evidence of skin erythema.

PRECAUTIONS If superinfection occurs due to overgrowth of nonsusceptible organisms, including fungi, discontinue antibiotic and start appropriate therapy.

In venereal disease, when coexistent syphilis is suspected, perform darkfield examination before therapy, and serologically test for syphilis monthly for at least four months.

Tetracyclines have been shown to depress plasma prothrombin activity; patients on anticoagulant therapy may require downward adjustment of their anticoagulant dosage.

In long-term therapy, perform periodic organ system evaluations (including blood renal, hepatic).

Treat all Group A beta-hemolytic streptococcal infections for at least 10 days. Since bacteriostatic drugs may interfere with the bactericidal action of penicillin, giving tetracycline with penicillin.

ADVERSE REACTIONS Gastrointestinal (oral and parenteral forms): anorexia, nausea, vomiting, diarrhea, glossitis, dysphagia, enterocolitis, inflammatory lesions (with oral overgrowth) in the anogenital region.

Skin maculopapular and erythematous rashes, exfoliative dermatitis (uncommon). Photosensitivity is discussed above (See **WARNINGS**).

Renal toxicity rise in BUN, apparently dose related (See **WARNINGS**).

Hypersensitivity urticaria, angioneurotic edema, anaphylaxis, anaphylactoid purpura, pericarditis, exacerbation of systemic lupus erythematosus.

Bulging fontanels, reported in young infants after full therapeutic dosage, have disappeared rapidly when drug was discontinued.

Blood hemolytic anemia, thrombocytopenia, neutropenia, eosinophilia.

Over prolonged periods, tetracyclines have been reported to produce brown-black discoloration of thyroid glands; no abnormalities of thyroid function studies known to occur.

USUAL DOSAGE Adults—600 mg daily, divided into two or four equally spaced doses. More severe infections, an initial dose of 300 mg followed by 150 mg every six hours, 300 mg every 12 hours. Gonorrhea. In uncomplicated gonorrhea, when penicillin is contraindicated, Randomycin (methacycline HCl) may be used for treating both males and females in the following clinical dosage schedule: 900 mg initially, followed by 300 mg q.i.d. for a total of 5.4 grams.

For treatment of syphilis, when penicillin is contraindicated, a total of 18 to 24 grams Randomycin (methacycline HCl) in equally divided doses over a period of 10-15 days should be given. Close follow-up, including laboratory tests, is recommended.

Eaton Agent pneumonia: 900 mg daily for six days.

Children—3 to 6 mg/lb./day divided into two to four equally spaced doses. Therapy should be continued for at least 24-48 hours after symptoms and fever subsided.

Concomitant therapy Antacids containing aluminum, calcium or magnesium impair absorption and are contraindicated. Food and some dairy products also interfere. Give one hour before or two hours after meals. Pediatric oral dosage forms should not be given with milk formulas and should be given at least one hour prior to feeding.

In patients with renal impairment (see **WARNINGS**), total dosage should be decreased by reducing recommended individual doses or by extending time intervals between doses.

In streptococcal infections, a therapeutic dose should be given for at least 10 days.

SUPPLIED Randomycin (methacycline HCl) 150 mg and 300 mg capsules, syrup containing 75 mg 5 cc methacycline HCl.

Before prescribing, consult package circular or latest PDR information.

Rev.

WALLACE PHARMACEUTICALS
CRANBURY, NEW JERSEY 08512

W

The medical school's graduating students dedicated the yearbook, *The Gray Matter*, to Dr. John H. Edmonds, Jr., professor of medicine, and Dr. Robert L. Gibson, assistant professor of anesthesia. Drs. Edmonds and Gibson were recipients last year of citations for excellence in clinical teaching.

* * *

Dr. William H. Boyce, professor and chairman of the Section of Urology, has been presented the highest research award of the American Urological Association (AUA).

He received the sixth annual Hugh Hampton Young Award at the association's meeting in St. Louis.

The award, which carries a \$2,000 prize, is given for outstanding contributions to the study of urinary tract infections. This year it also recognized the overall excellence of the total program of research and training in urology at the medical center.

Dr. Boyce is a six-time winner of research awards from the AUA.

* * *

Dr. Jesse H. Meredith, professor of surgery, has been installed as president of the North Carolina Chapter, American College of Surgeons.

Dr. Meredith is the third faculty member from Bowman Gray to head the chapter. Past presidents include Dr. Felda Hightower, professor of surgery, and Dr. William H. Sprunt, Jr., clinical professor emeritus of surgery.

* * *

Dr. Robert C. McKone, associate professor of pediatrics, received the highest award given to a member of faculty during the student-faculty awards ceremony in May.

Dr. McKone was presented the second annual Award for Teaching Excellence. He was also one of four recipients of citations presented by the senior class for excellence in clinical teaching.

Dr. N. Sheldon Skinner, professor and chairman of the Department of Physiology, was presented the Golden Apple Award for teaching excellence in the basic medical sciences.

Receiving citations in clinical teaching were, in addition to Dr. McKone, the following: Dr. Francis M. James, associate professor of anesthesia; Dr. Eas Allen, clinical assistant professor of medicine; and Dr. Walter M. Roufail, clinical instructor in medicine.

House officer teaching awards went to Dr. Percy E. Miller, resident in otolaryngology, and Dr. Sara H. Sinal, resident in pediatrics.

* * *

Dr. Paul C. Bucy, an internationally prominent neurosurgeon, has been appointed to the medical school faculty as clinical professor of neurology and neurosurgery.

He is a professor emeritus and former director of

neurosurgery at Northwestern University Medical School. He now lives in Tryon, N. C.

Dr. Bucy is best known for his work on the pathology of brain tumors, the anatomy and physiology of the central motor system, the treatment of abnormal movements and the development of centers for spinal cord injury.

He is president of the American Neurological Association and a past president of the World Federation of Neurosurgical Societies, the Second International Congress of Neurological Surgery, the Society of Neurological Surgeons and the American Association of Neurological Surgeons.

* * *

Dr. Jimmy L. Simon, professor and chairman of the Department of Pediatrics, has received special recognition for teaching excellence from the 1974 graduating class of the University of Texas Medical Branch at Galveston.

Dr. Simon was deputy chairman of pediatrics at Galveston before joining the Bowman Gray faculty.

He was presented the James W. Powers Award, which is the highest honor the students at the University of Texas Medical Branch can bestow upon a faculty member.

This is the second time Dr. Simon has won the Powers Award.

* * *

Dr. James A. Harrill, professor and chairman of the Section on Otolaryngology, has been elected president-elect of the American Laryngological, Rhinological and Otolological Society.

Dr. Harrill will be installed as president during the society's annual meeting next April in Atlanta.

He has been a fellow of the society since 1950 and has served as both secretary and vice president of the society's southern region. He also served on the governing council several times.

* * *

Dr. Paul M. James, Jr., associate professor of surgery, has been elected to a four-year term on the Executive Board of Directors of the American Trauma Society.

News Notes from the—

UNIVERSITY OF NORTH CAROLINA DIVISION OF HEALTH AFFAIRS

Dr. George D. Allen, assistant professor of speech and hearing sciences at UNC at Chapel Hill, has been awarded a \$41,000 grant from the National Science Foundation to support his research into the development of timing control in human speech.

He hopes to shed light on underlying neural control processes. His research will examine the range

of timing abilities in normal adult speakers as well as the development of this ability in children. In doing so, he hopes to help children with speech problems.

* * *

The potential of new programs intended to prevent mental retardation among vulnerable infants and young children was evaluated at a national conference which began here in May.

The President's Committee on Mental Retardation (PCMR) called together approximately 300 researchers, public officials, parents of retarded children, and professionals in the field for the four-day meeting on the UNC campus at Chapel Hill.

The programs examined were based on the theory that many children who would otherwise become mentally retarded can be helped to develop normally if they are identified early in life.

* * *

Dr. Ralph H. Boatman, director of the UNC Office of Allied Health Sciences in Chapel Hill, has been named director of the University's Office of Continuing Education in Health Sciences.

Dr. Boatman moved into the position vacated in May by Francis C. Lindaman who moved to New York City to join the City Health Department's health education program.

The office of continuing education which Dr. Boatman heads performs a planning and coordinating service for the Division of Health Sciences and its five schools. It also is responsible for certain development and manpower information services for these schools and for special conference planning and coordination.

* * *

Dr. Royce Montgomery, associate professor of anatomy at the UNC School of Medicine in Chapel Hill, was awarded the Richard F. Hunt Memorial Award for excellence in undergraduate teaching at the annual Spurgeon Dental Society awards banquet.

The award is presented annually by the Loblolly Dental Study Club of Eastern North Carolina in memory of the late Dr. Richard F. Hunt of Rocky Mount. Dr. Hunt graduated from the UNC School of Dentistry and was an outstanding civic and professional leader.

The award recipient is determined by a joint faculty and student committee of the UNC School of Dentistry at Chapel Hill. Montgomery teaches gross anatomy and is an honorary member of the dental fraternity Psi Omega.

* * *

Dr. Jim Hart, Raleigh, North Carolina orthodontist, has been elected president of the Alumni Association of the UNC School of Dentistry in Chapel Hill. Serving with Dr. Hart are Dr. Eugene Howden, vice president, and Dr. David Simpson, secretary-treasurer. Both are on the faculty of the UNC School of Dentistry.

* * *

Researchers at the UNC School of Medicine in

Chapel Hill, probing for elusive facts in the bleeding disorder, von Willebrand's disease, have come up with a new complication.

Dr. Kay M. Sarji and R. D. Stratton presented their findings at a Federation of American Societies for Experimental Biology meeting, April 11, in Atlantic City, New Jersey. Both Sarji and Stratton are at the medical school's Department of Pathology.

Until recently, there was no way of measuring the von Willebrand factor, an essential clotting element in the blood. Using a newly-developed test, the researchers found that plasma from one patient with von Willebrand's disease prohibited platelet clumping in normal blood, while plasma from other von Willebrand patients did not.

Since two separate clotting factors are missing in von Willebrand's disease, the refractory condition which was not previously recognized in the disease could be caused by an inhibitor to either the antihemophilic factor or to the von Willebrand factor. The patient with this newly-recognized complication had an inhibitor only to the von Willebrand factor. The researchers believe the new inhibitor is an antibody.

* * *

Dr. Kenneth M. Brinkhous, Alumni Distinguished Professor at the UNC School of Medicine and an internationally recognized researcher, was honored by the Department of Pathology at a symposium in April which focused on Dr. Brinkhous's special interests, hemostasis and thrombosis.

Dr. Brinkhous, who made the first of his eight major medical discoveries while still a medical student, has concentrated on the clinical treatment of hemophilia and other blood disorders relating to clotting mechanisms.

More recently he has been concerned with patients who have the opposite problem—a clotting mechanism which endangers the patient's life.

* * *

Dr. Daniel Test Young, professor of medicine at the UNC School of Medicine in Chapel Hill, has won the Thomas Jefferson Award for 1974.

The cash prize is made each year to the member of the University community whose life and activities show the qualities of integrity and character that marked the life of Thomas Jefferson and which would have been recognized as essential to the political, religious, and intellectual advancement of society.

Dr. Young, a graduate of Guilford College and Harvard Medical School, came to UNC in 1955. He has directed the Cardiac Catheterization Laboratory at N. C. Memorial Hospital and served as president of the N. C. Heart Association.

* * *

Dr. Betsy J. Stover, associate professor of pharmacology at the UNC School of Medicine in Chapel Hill, has been appointed to the Fellowship Review Panel of the National Science Foundation. She will

ve on the Biomedical Sciences Panel, one of 12
nels that review fellowship applications.

* * *

A \$25,000 trust fund to help support the UNC
School of Medicine's research and teaching programs
peripheral vascular disease has been established
Mr. and Mrs. Calvin Kovens of Chapel Hill.

The gift to the Department of Surgery is an ex-
pression of appreciation for the medical care ren-
dered their son, Scott, in the fall of 1973.

* * *

Dr. Paul L. Munson, Sarah Graham Kenan Pro-
fessor of Pharmacology and Endocrinology, has been
elected president of the Association for Medical
School Pharmacology (AMSP).

* * *

Dr. Charles F. Gregory, professor and chairman
orthopaedic surgery at the University of Texas
Southwestern Medical School, is the 1974 R. Beverly
Taney Visiting Professor at the UNC School of
Medicine.

* * *

A senior medical student at the UNC School of
Medicine in Chapel Hill has had his third book pub-
lished by Warner Paperback Library. He also has
started a publishing company and published his first
book.

Karl Edward Wagner has added *Bloodstone* to his
career science-fiction novels and short stories.

Wagner, who received his M.D. degree on May 12,
plans to specialize in psychiatry.

* * *

A member of the UNC School of Pharmacy
faculty, Dr. Claude Piantadosi, is collaborating in
cancer research with Dr. Fred Snyder, a senior sci-
entist at the Oak Ridge, Tennessee Institute of Nu-
clear Studies and other scientists to try to learn how
cancer cells are formed in cancer cells and in normal cells.

This year the project is financed by two grants
from the National Institutes of Health, totalling some
\$5,000. Other parts of the lipid study are supported
by funds from the Atomic Energy Commission,
the American Cancer Society, and the National Can-
cer Institute.

* * *

Barbara Lowe Bumgarner of Greensboro was pre-
sented the Senior Recognition Award by the Divi-
sion of Physical Therapy. The award is presented by
the professional staff and faculty to the student in the
top one-third of the class with the total best perfor-
mance.

* * *

The first Mindel C. Sheps Award in Mathematical
Photography was presented at the annual meeting of
the Population Association of America in New York
City in April.

Established as a memorial to the late Dr.
Mindel C. Sheps of the UNC School of Public Health
faculty, the award was given to Dr. Ansley J. Coale,
professor of economics at Princeton University.

Dr. Cecil G. Sheps, vice chancellor of health sci-
ences at the University of North Carolina at Chapel
Hill, presented the \$1,000 award to Dr. Coale. Dr.
Sheps was the husband of the late Dr. Mindel Sheps.

The award was established by the Mindel C. Sheps
Memorial Fund and is sponsored by the Population
Association of America and the UNC School of
Public Health in Chapel Hill.

* * *

Dr. C. Arden Miller, professor of maternal and
child health at the UNC School of Public Health
and president-elect of the American Public Health
Association, has been elected to the board of trustees
of Appalachian Regional Hospitals (ARH), a non-
profit health care system serving ten communities
in Kentucky, Virginia, and West Virginia.

AMERICAN ACADEMY OF FACIAL PLASTIC AND RECONSTRUCTIVE SURGERY, INC.

Carl N. Patterson, M.D., Durham, N. C., was
chosen president-elect (1975) of the American
Academy of Facial Plastic and Reconstructive Sur-
gery, Inc., at their April 1974 meeting in Palm Beach,
Florida.

Dr. Patterson is currently on the staff of McPherson
Hospital in Durham. He is Assistant Clinical
Professor in Surgery (otolaryngology) at Duke Uni-
versity Medical Center, and Clinical Consultant in
Surgery (otolaryngology) at North Carolina
Memorial Hospital. He is on the attending staff at
Watts Hospital and Lincoln Hospital, Durham, and
Consultant in Otolaryngology at Murdock and John
Umstead Hospitals, Butner, and at Dorothea Dix
Hospital, Raleigh.

After graduating from the University of Maryland
Medical School in 1944, Dr. Patterson interned at
Mercy Hospital in Baltimore and completed his resi-
dency in otolaryngology at Mercy Hospital in 1946.

Dr. Patterson is currently a member of the Board
of Directors of the American Academy of Facial
Plastic and Reconstructive Surgery, Inc. He is Chair-
man of the Board of Directors of the Training Center
for Hearing Impaired Children in Durham.

BOY SCOUTS OF AMERICA

The medical Exploring program of the Boy Scouts
of America (BSA) is having a definite impact in
North Carolina. Operating under a three-year grant
from the AMA, the BSA's Exploring Division is
expanding its special interest program in medicine
and the allied health careers.

Robert G. Maxfield, National Director of medical
Exploring, was in North Carolina recently assisting
local Scouting officials in Raleigh, Durham, Fayette-
ville, Chapel Hill, and Greensboro.

Presently, 620 young adults are actively involved

in the 36 medical and health career Explorer posts in North Carolina. Career interest surveys conducted by local Exploring divisions indicate a sufficient interest in health careers to greatly expand the program. The interest in entering a health career is very

high among North Carolina youth. Exploring offers these young adults an opportunity to experience an in-depth exposure to the realities of a health career and thus better prepare them for the necessary training and education.

Month in Washington

With the exception of a possible last-minute catastrophic bill to the liking of both the Senate and the House, the prospects for a national health insurance (NHI) bill this year appear to be fading. Preoccupied with the possible impeachment and other matters, the pace of House and Senate hearings on NHI has definitely slowed, despite a strong desire of Republicans and Democrats to take a widely popular health measure with them to the polls this November.

Its late April testimony on NHI before the House Ways and Means Committee behind it, the American Medical Association again advanced its Mediscredit proposal for NHI before the Senate Finance Committee at the end of May.

Senate Finance Committee chairman Russell Long (D-La.) and other committee members heard AMA president Russell Roth, M.D., president-elect Malcolm Todd, M.D., and Ernest Livingstone, M.D., chairman of the AMA Legislative Council, support the Mediscredit measure.

"As the nation's largest association of actively practicing physicians, the ones who will be called upon to provide the professional services which are contemplated under any program which may be authorized by Congress, we feel that our viewpoints are extraordinarily important," Dr. Roth told the committee.

"If we are to meet the principal needs, not only of the aged and the poor, but of the vast middle-income group, it would seem we must endeavor to provide basic coverage for medical service and, if possible, add to this protection against ruinous catastrophic major medical expense. (Senators Long and Abraham Ribicoff, D-Conn., are sponsors of a catastrophic-only type NHI proposal).

"We appreciate the economies of providing only catastrophic coverage, but feel that it will meet too few of the needs and will prove very difficult to administer. We appreciate the appeal of first dollar coverage but recognize the inordinate expense involved.

"The catastrophic coverage should be adjusted to

ability to pay, since it is obvious that an amount which could be easy for the well-to-do family to pay could be disastrous for the much larger group of middle and low-income individuals. If the insurance is to protect, it must be operative at the level of need.

"If I provide \$10 worth of service for my patient and he pays me directly, I have earned \$10 and he has spent \$10. If, instead, money is to be collected from the patient as a tax to be transmitted to Washington, processed, transferred to another agency, processed, passed to an intermediary, processed, paid out as a benefit, and then reviewed for appropriateness, I will need to leave it to others to estimate how much more must be collected from the patient to yield the \$10 necessary to cover the service rendered. Each complicating step in the process contributes to a shrinkage in service purchased by the medical dollar.

"We believe that the public will look with dismay on a financing mechanism which increases the Social Security tax by four percent, as with the Kennedy Mills proposal.

"We have enthusiasm for the financing mechanism in the Mediscredit bill which uses tax credits to minimize the number of dollars making a round trip to Washington as tax to return as a shrunken benefit and which places the obligation to contribute the share on those who have the ability to pay all or part of their premium cost. It uses an existing governmental collection agency, minimizes new demands for an increase in bureaucracy, and reduces administrative costs.

"Finally, there is the matter of administering the program. There is precious little evidence that any particular economy or efficiency results from government health programs, but a growing body that the opposite may be true.

"In the case of National Health Insurance, we feel assured that if any part of the funding derives from Social Security taxes there would be a compulsion for Social Security control of the program.

"We are confident that the administration of the

**"I'm sorry,
Doctor!
You're not
going to be
able to
continue
your
practice."**



Have you ever stopped to consider the effect on yourself and your family if this were ever to happen to you? Even when you are covered with insurance for the medical and hospital bills, the expenses of day-to-day living can quickly use up the money it has taken you years of work to accumulate.

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program will best be accomplished by existing entities in the field. Federal involvement, while inescapable when dealing with federal tax dollars, should be kept minimal.

"We again believe that our Mediredit program fulfills these objectives in respect to administration more aptly than does any other proposal to date. We believe the public, in opinion poll after poll, has reiterated its high degree of confidence in the medical profession and its low esteem for bureaucratic administration. We believe that there is validity in other current public opinion polls which indicate that the chief national concern is over inflation." Dr. Roth concluded.

After Dr. Roth had read the statement, Chairman Long said he agreed with the many things the AMA official had talked about, particularly the concern regarding wastage of funds that are channeled through Washington.

Long asked about the merits of a tax credit as opposed to a payroll tax. Dr. Roth said the tax credit is the most equitable in that it relies on the federal income tax which provides an accurate gauge of family income. The money retained by the individual for health insurance does not "have to make the round trip to Washington."

* * *

First witness before the Senate Finance Committee hearing was Health, Education and Welfare Secretary Casper Weinberger who urged that an NHI bill

"should be the highest priority item in the closing months of this Congress." He expressed hope that the areas of disagreement between competing NHI proposals would not be found insurmountable.

The Secretary, however, criticized all of the competing proposals, with special attention to the Mills Kennedy and the Health Security bill of organized labor. "Both vest too much power with the federal government," Weinberger said.

At the sometimes stormy meeting, Sen. Vance Hartke (D-Ind.) and Sen. Clifford Hansen (R-Wyo.) chided the Secretary for criticizing the AMA plan, pointing out that Mediredit had powerful backing.

Sen. Hansen said that when negotiating time arrives, strong consideration should be given to the Mediredit bill which has 182 sponsors, including five members of the Finance Committee and 11 members of the House Ways and Means Committee.

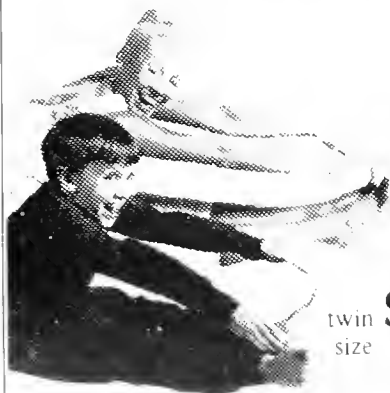
Hansen said that the Council of Economic Advisors and the Brookings Institute have recommended that the tax credit method of financing employed by Mediredit should be used in broad federal programs. Weinberger said he preferred tax credits to a Social Security payroll tax, but thought general revenue financing was best. Hansen said controls could impede productivity and cause personnel to leave the health system.

Sen. Hartke said Mediredit has more sponsors than all other NHI bills combined. Weinberger

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omised to keep that in mind while conferring with Congress. "You are going to have to deal with 182 us somewhere along the line," Hartke said. "Not t 'President' Kennedy or 'President' Mills."

Hartke said that despite Weinberger's criticism of edicredit the fact is that all NHI bills deal basically h financing, including the Administration's plan hich doesn't provide anything concrete about anging the system.

Sen. Abraham Ribicoff (D-Conn.) said the Ad-nistration was being deceptive about the true costs its program. He contended that Weinberger is ling the American people they will have a \$55 lion "free lunch."

"You are dealing with the most complex social d economic program in the history of our nation," bicoff said. "If all sides can't agree to work out a mpromise there will be no program."

Sen. Long added that Americans must be given all the facts about exactly what an NHI bill would st them, pointing out that he couldn't "... see a e lunch in any of them."

* * *

Meanwhile, on the House side, the Ways and eans Committee completed the second month of e-day-a-week hearings on NHI.

It appears that almost every health-related or-nization in the country wishes to be heard. For ample, one day's hearing saw the following organi-tions testify before the powerful House Committee: ue Cross Association, National Medical Associa-on, American Osteopathic Society, National Council Health Services, American Podiatry Assocoeation, ational Council of Community Health Centers, eterans of Foreign Wars, and Americans for Demo-atic Action.

Some sparks flew when Andrew Biemiller, direc-r of the AFL-CIO's Department of Legislation, eappeared in place of AFL-CIO president George eany. Biemiller, in effect, took an all-or-nothing roach, insisting that, unless a bill similar to the iginal Kennedy-Griffiths measure is approved, it ould be better to wait until next year.

Of major interest to most Capitol Hill watchers the fact that House Ways and Means Committee airman Wilbur Mills (D-Ark.), co-sponsor of the ennedy-Mills proposal, attended only the first aring.

* * *

Labor's stand drew criticism from committee mem-ers, some of whom stressed a theme that there is ong pressure for Congress to act this year, es-pecially on a catastrophic bill.

Biemiller said, "If Mills-Kennedy is this commit-ee's idea of a compromise, then I must say, in all ndor, we will oppose it." Labor's strongest criti-sm came on the Long-Ribicoff bill. "It is not tional health insurance, and does not pretend to be. ould be, therefore, a catastrophe if the Congress acted catastrophic insurance," said Biemiller.

Rep. Omar Burleson (D-Texas) told Biemiller, "You are not really willing to compromise at all." He said labor expects a Congress of a "different nature" next year so that it can get all it wants.

Biemiller replied that the elections of 1964 caused many people in Congress to change their minds about Medicare, and resulted in its passage in 1965.

Congressional backers of the Mediecredit national health insurance plan rallied on the floor of the House of Representatives in early May to praise the NHI approach developed by the AMA.

A score of speakers rose to urge congressmen and senators to join them in backing Mediecredit, which has more sponsors (182) than all other NHI pro-posals combined.

"One reason the legislation has such support in the Congress is that it is based on some solid princi-ples which are both realistic and workable," declared Rep. Omar Burleson (D-Texas).

Rep. Richard Fulton (D-Tenn.), principal co-sponsor and, like Burleson, a member of the key House Ways and Means committee, told the House that "Mediecredit's benefits are comprehensive; its ability to meet our present needs seem unarguable; its price tag, in terms of new tax dollars, seems to be within the nation's means; and, the method it pro-poses for financing the plan appears to me to rest fairly on the taxpayer without overburdening our Social Security system."

Rep. Joel Broyhill (R-Va.), chief GOP sponsor and a high-ranking member of the Ways and Means panel, said 182 members of Congress "have seen through the fog of rhetoric and printed word swirling about national health insurance. They have chosen Mediecredit. I invite more of you to come aboard in support of a sensible piece of legislation."

Broyhill said Mediecredit enjoys two prime virtues —free choice of health care setting and physician, and "the American philosophy of voluntarism."

Rep. Tim Lee Carter, M.D., a Kentucky Repub-lican said no other NHI proposal offers as liberal a psychiatric benefit as Mediecredit.

The American Psychiatric Association had pointed out that Mediecredit stands alone in this regard. "All other NHI proposals contain some discrimination that separates treatment of the mentally ill from that of the physically ill," noted Dr. Carter.

"Mediecredit is a workable approach. The medical profession and the public want a plan that keeps the federal government's role at a minimum. From the standpoint of benefits, efficiency, financing, and ac-ceptability, I am convinced that the Mediecredit ap-proach is by far the best we have before us," Carter said.

Rep. Jerry Pettis (R-Calif.), a member of Ways and Means said his colleagues should consider foreign national health systems, and he cited the following cases: (a) In Sweden the per capita health care costs increased by 614 percent from 1950 to 1966, com-pared to 174 percent in the United States. Since 1960

medical costs in Sweden have increased almost 900 percent. (b) In West Germany there is a serious maldistribution of medical personnel. (c) Norway reports a shortage of practitioners. (d) Hospital rates in Canada are higher and length of stay longer than in the U.S.

Pettis said we had better be very careful about tinkering with our present system. "Certainly there is clear warning in these facts to all of us that we should not abandon the strengths of the American system for the type of health delivery system which has been developed in some other country," he added.

Rep. Peter Kyros (D-Maine), said Mediredit "goes right to the heart of the catastrophic problem. No matter how large or small a family's income, its medical expenses would never exceed ten percent of that income," said Kyros. "This would be a tremendous reassurance to every family. At the same time, it offers a fair method—a sliding scale—for sharing the country's major health costs."

Rep. Robert Michel (R-Ill.), said Mediredit "meets the true test of any workable national health insurance plan—it provides access to high quality medical care to all Americans on the basis of sharing the cost in an equitable fashion. The poor would pay nothing. In a fair way, the better-off would pay on a sliding scale that reflected their income. Most importantly, this legislation would insure that no American would have to go bankrupt because of a catastrophic illness."

* * *

The Professional Standards Review Organization (PSRO) program is off to "an incredibly bad start" and is encountering increasing physician resistance, the American Medical Association has told Congress.

AMA President Russell Roth, M.D., testifying before the Senate Finance subcommittee on health, said that 13 state medical societies have formally declared for repeal of the PSRO law and that 29 societies support a policy of amendment or repeal, or both (as of May 7, 1974).

"We cannot be precise in numbers, but it seems evident that, as understanding of the PSRO law spreads, the resistance to it grows," said Dr. Roth.

The health subcommittee, chaired by Sen. Eugene Talmadge (D-Ga.), slated two days of hearings on

the spreading controversy over the PSRO law.

Dr. Roth said "The best efforts of the legislator involved, the staff of the Senate Finance Committee the staff of the PSRO administrative office in HEW and physicians from AMA, from assorted state medical societies and specialty medical organizations, have not succeeded in creating in the profession the climate of acceptance and cooperation essential to success. The fault does not lie with the sincerity or intensity of the effort to cooperate—it lies with the basic ineptitudes of the statute."

The AMA President said it has been seriously proposed that, because of the bad start on PSRO, it may be best to fall back, regroup, and start again. The official AMA position, he noted, is that repeal may need to be considered if amendatory patchwork is unacceptable.

Robert Hunter, M.D., chairman of the AMA special advisory committee on PSRO and a member of the AMA board of trustees, described to the senators the AMA's extensive "constructive efforts" to cooperate with congress and the government to make PSRO work.

Edgar T. Beddingfield, Jr., M.D., vice chairman of the AMA's council on legislation, said "The PSRO law has created a great deal of confusion and misunderstanding."

"Sections on norms of health care services are patently contradictory, and we anticipate that the net result will be that the norms of care will be viewed as rigid federal minimum requirements. Patients and the profession alike are legitimately concerned with the prospect of cookbook medicine," Dr. Beddingfield said. He recommended that the "norms" should be guides for care and should be clearly understood as initial points of evaluation and review. "Further more," Dr. Beddingfield said, "such guides must not be substituted for the medical judgment of individual physicians in the delivery of health care services."

During the two days of hearings, some 20 medical associations, state societies, and speciality groups testified their general misgivings with respect to the workability of the statute. Throughout the hearings Sen. Wallace Bennett (R-Utah), against, at times shouting and hostile witnesses, stoutly defended PSRO. "I won't live long enough to see repeal of PSRO," he remarked.

Book Reviews

Current Pediatric Diagnosis and Treatment. By C. H. Kempe, M.D., H. K. Silver, M.D., and Donough O'Brien, M.D. 3rd Edition. 1,020 pages. Price, \$12.00. Los Altos, California: Lange Medical Publishers, 1973.

This book represents a compromise between the comprehensiveness of a standard pediatric textbook and the briefness of a handbook. By and large, this text is completed quite admirably. Especially valuable are the current references in the book, with many subjects being indexed through 1973. The publication is quite up to date—a distinct advantage over some of the traditional textbooks which have a rather long gap between the time the books were written and the time they were printed. The tables on drug therapy, antibiotic therapy, and the interpretation of chemical values are especially useful.

The only major disadvantage of the book is the one inherent in all such attempts, i.e., it lacks information on the pathophysiology that is essential to the students' understanding. On the other hand, for the preceptor, the book is certainly a bargain for the shelf of a family physician, pediatric resident, or practitioner.

JIMMY L. SIMON, M.D.

The Cardiac Arrhythmias. By Brendan Phibbs, M.D. 205 pages. Price, \$7.50. 2nd edition. Saint Louis: C. V. Mosby Co., 1973.

This book is intended not for the cardiologist, but for the beginning student, nurse, or physician who is interested in being able to recognize most cardiac arrhythmias.

The Cardiac Arrhythmias is divided into four parts. Part I is a brief review of basic anatomy and physiology. Part II delves into the simple arrhythmias and mechanisms of origin, recognition, and treatment. Part III goes into more complex arrhythmias including Digitalis-induced arrhythmias, A-V dissociation, sick sinus syndrome, and arrhythmias seen

in the coronary care unit. Part IV has to do with drugs, dosages, and indications for use. It also includes a discussion of pacemakers, defibrillators, and cardioversion.

In the preface the author states that most scientific writing is needlessly obscure and can be described in simple, clear English. He also states that most writers do not take the trouble to do this. I was subsequently disappointed to find that the author did not heed his own advice in many instances, and on occasion he is quite verbose. Aside from this deficiency and a few poor reproductions of EKG's, this very nice little book is recommended.

JOHN EDMONDS, M.D.

Dentistry and the Allergic Patient. Claude A. Frazier (ed). 429 pages, with illustrations and tables. Price, \$18.75. Springfield: Charles C. Thomas, 1973.

This well-documented book contains altogether 31 pages of references at the end of the chapters, ten pages of author index, and 52 pages of subject index. The 22 contributors have varied and interesting backgrounds.

Most dentists will agree with the statement that "it behooves every dentist to become well versed in allergy"; however, many members of the profession might be surprised to find x-rays of the maxillary teeth placed upside down.

This book can be helpful to every member of the health team—the physician, the dentist, the occupational therapist, the physical therapist, and all other providers of health care. When one is aware of the allergic reactions, he can help the patient by sharing pertinent information with other members of the health care team.

Some problems discussed as being peculiar to members of the dental profession are in reality problems which are common to all members of society.

DAVID L. BEAVERS, D.D.S.

In Memoriam

Clyde R. Hedrick, M.D.

Clyde R. Hedrick, M.D., at the age of 73, died shortly after admission to Caldwell Memorial Hospital, Lenoir, North Carolina on December 18, 1973. Dr. Hedrick was born in High Point, North Carolina on May 31, 1900, and in his early childhood he moved to Lenoir with his parents, the late Ivey Tilton and Cora R. (Hedrick).

Dr. Hedrick was a graduate of Lenoir High School and graduated from the University of North Carolina in Chapel Hill. He received his M.D. degree in 1925 from Georgetown University Medical Center in Washington, D. C. He interned at Stuart Circle Hospital in Richmond, Virginia.

He returned to Lenoir and established his medical practice in 1926 and was in continuous practice since that time. Through the years Dr. Hedrick made an indelible contribution to the civic, religious, and medical aspects of community life in Caldwell County. Dr. Hedrick served Caldwell County Medical Society and the State Medical Society in many capacities including participation on the State Board of Medical Examiners. In addition to numerous positions held in the medical field, he was named to the American Men of Medicine Personalities of the South. Dr. Hedrick was one of the initial organizers of Caldwell Memorial Hospital and was the first Chief of Staff.

A week prior to his death, he was named Caldwell County Man of the Year as recipient of the L.A. Dysart Award presented by the Lenoir-Caldwell County Chamber of Commerce.

Dr. Hedrick was a past president of the Lenoir Kiwanis Club, a member of the North Carolina Historical Society, had been a post commander of the American Legion, and was a member of the Pythian Lodge and Moose Lodge. Some of the early civic activities he initiated included the organizing of the first Lenoir High School football team in 1927 and serving as the team physician since that time.

Dr. Hedrick was a member of the Zion United Church of Christ and was a member of the board of managers of Nazareth Children's Home.

He was married to the former Stella Mae Lamkin of Selma, Alabama in June, 1929. Surviving are his widow, three daughters, one brother, and nine grandchildren. He was preceded in death by two brothers including Dr. Paul E. Hedrick, a Lenoir dentist, and a sister. Burial was in the Blue Ridge Memorial Park.

Dr. Hedrick contributed greatly to the civic, religious, and medical affairs of Lenoir and Caldwell County. He will be missed by his community and the Caldwell County Medical Society.

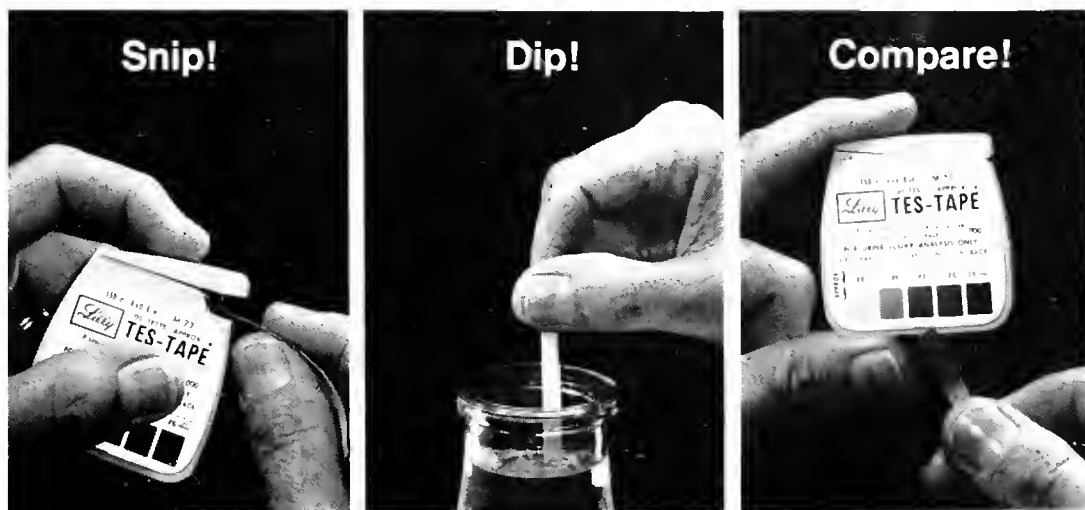
CALDWELL COUNTY MEDICAL SOCIETY

When any substance is detained in the gullet, there are two ways of removing it, either by extracting it, or pushing it down. The safest and most certain way is to extract it; but this is not always the easiest; it may be more eligible sometimes to thrust it down, especially when the obstructing body is of such a nature, that there is no danger from its reception into the stomach. The substances, which may be pushed down without danger, are all common nourishing ones, as bread, flesh, fruits, and the like. All indigestible bodies, as cork, wood, bones, pieces of metal, and such-like, ought, if possible, to be extracted, especially if those bodies be sharp pointed, as pins, needles, fish-bones, bits of glass, etc.—*William Buchan: Domestic Medicine, or a Treatise on the Prevention and Cure of Diseases by Regimen and Simple Medicines, etc., Richard Folwell, 1799, p. 407.*

NORTH CAROLINA

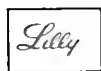
Medical Journal

THIS ISSUE: The President's Address: Shoals Ahead, Frank R. Reynolds, M.D.; Certain Ethical Aspects of Biomedical Research: Evolution of Concepts of Ethical Standards, James F. Toole, M.D., LL.B.; Reimplantation of Extremities by Microvascular Suture, James G. Boyes, Jr., M.D.



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The President's Address

Shoals Ahead

Frank R. Reynolds, M.D.

gives me a great sense of humility and pride to have been chosen to serve as your President for the coming year. One should never forget, however, that honors never fail to bring responsibility, and we must accept one without having placed on us the burden. At a time such as this, one has an acute feeling of personal inadequacy in confronting the numerous, complex issues that lie ahead, since they usually have no simple, immediate solution. Public interest in quality medical care has never been higher, and perhaps never less understood by the majority of the people to whom it is being administered. The alphabet game has reached a new high with acronyms like PSRO, CHP, RMP, HEW, SSA, NHI, JCI, CPT, QAP, CHIP, and an occasionally muttered SOB at every medical meeting. Obviously, one must quickly learn the new language if he is to understand the game.

I have spent the past year taking numerous trips around the state and nation, attempting to prepare for the coming year as your President. One cannot help being impressed by the quality of the meetings sponsored by the AMA, as well as the efficiency of the staff and the tremendous knowledge and ability of the officers.

Since I am from the coastal area, permit me to use some nautical terminology to describe our voyage for the coming year. I will try to point out "shoals" that lie ahead, and I will enlarge upon what I feel to be of greatest interest to us individually and collectively.

FIRST SHOAL: ACCESS TO APPROPRIATE MEDICAL CARE

There is no doubt in anyone's mind that we in the United States have the best system of medical care in the world — the private practice, fee-for-service system. However, I am sure that all of you can remember times when people needing our services had difficulty gaining access into our system, usually because they had a lack of knowledge concerning the system. If a patient is moving from one city to another and has the foresight to obtain a letter of referral to another physician, then he usually has no difficulty in obtaining the needed continuing medical services. The referring physician can see that the family receives the type of medical care that is needed, or it might be said that the patient is referred "into the system." However, if a family moves into a new community without physician contacts and suddenly seeks to obtain the services of a physician, it can be very time-consuming, or even impossible. Dollars are not the primary deterrent to access to appropriate health care. Ignorance of the system is the deterrent. In large cities, and in most large counties, there is a hospital emergency room where care can be received; however, the availability of emergency care does not gain the patient access into the system unless the physician on call agrees to furnish continuing care for the family. Each medical society needs to make available information that will allow newly relocated families to gain access to a primary care physician.

I also predict much wider use of the hospital emergency room for nonemergency care and increased use of continuous physician coverage in our emergency rooms. As far as the public is concerned,

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they use the emergency room for after-hours illnesses or injury because that is the only place they know to go. Whether or not we feel that the service is being abused, this practice continues to grow in North Carolina. There were more than 1.5 million visits to emergency rooms in our state last year. One must admit that this is an expensive type of care, but the cost does not seem to cool the demand.

Another trend in medical practice is toward the regionalization of maternal and infant care as a practical, and reasonably obtainable, method for the reduction of perinatal mortality and morbidity. North Carolina ranks approximately fortieth in perinatal mortality. Therefore, the governor's task force for maternal and infant care, chaired by Dr. George Brumley, has recommended the regionalization approach.¹

SECOND SHOAL: PHYSICIAN SHORTAGE

Our Society has long recognized the physician shortage in North Carolina. In May 1971, the House of Delegates passed the Lincoln County Medical Society's resolution asking the North Carolina Medical Society to undertake a study to determine the number of additional medical students needed. The resolution called for another study to determine the most economical and efficient way to educate these students.

President Styron requested the North Carolina Joint Conference Committee on Medical Care to undertake these studies. To implement this monumental request, a subcommittee of the Joint Conference Committee was established, with Dr. John Glasson as Chairman. After extensive in-depth studies for a period of more than a year, the final report was presented to the House of Delegates in May 1973, and their recommendations were passed. Their recommendation to utilize the present four-year medical schools and increase both the number of medical students and the percentage of North Carolinians was most timely. I predict that the increasing emphasis on training primary care physicians and the increasing number of North Carolinians staying home to practice will alleviate, within the next few years, the acute physician shortage; however, the distribution of these physicians continues to be another problem. Since the State Legislature, in its wisdom, has elected to increase the number of medical students at East Carolina, I can assure them that they will be welcomed into the system with open arms.

The shortage of primary care physicians and their maldistribution has been studied in-depth by Dr. Kemp Jones and his Committee on Community Medical Care.² I recommend strongly that everyone read their report, "Need for More and Better Distributed Primary Care Physicians in North Carolina," in the April 1974 issue of the *NORTH CAROLINA MEDICAL JOURNAL*. I feel certain that many of their recommendations will be followed in the coming

years and that we will see continued improvement in the distribution of primary care physicians in our state.

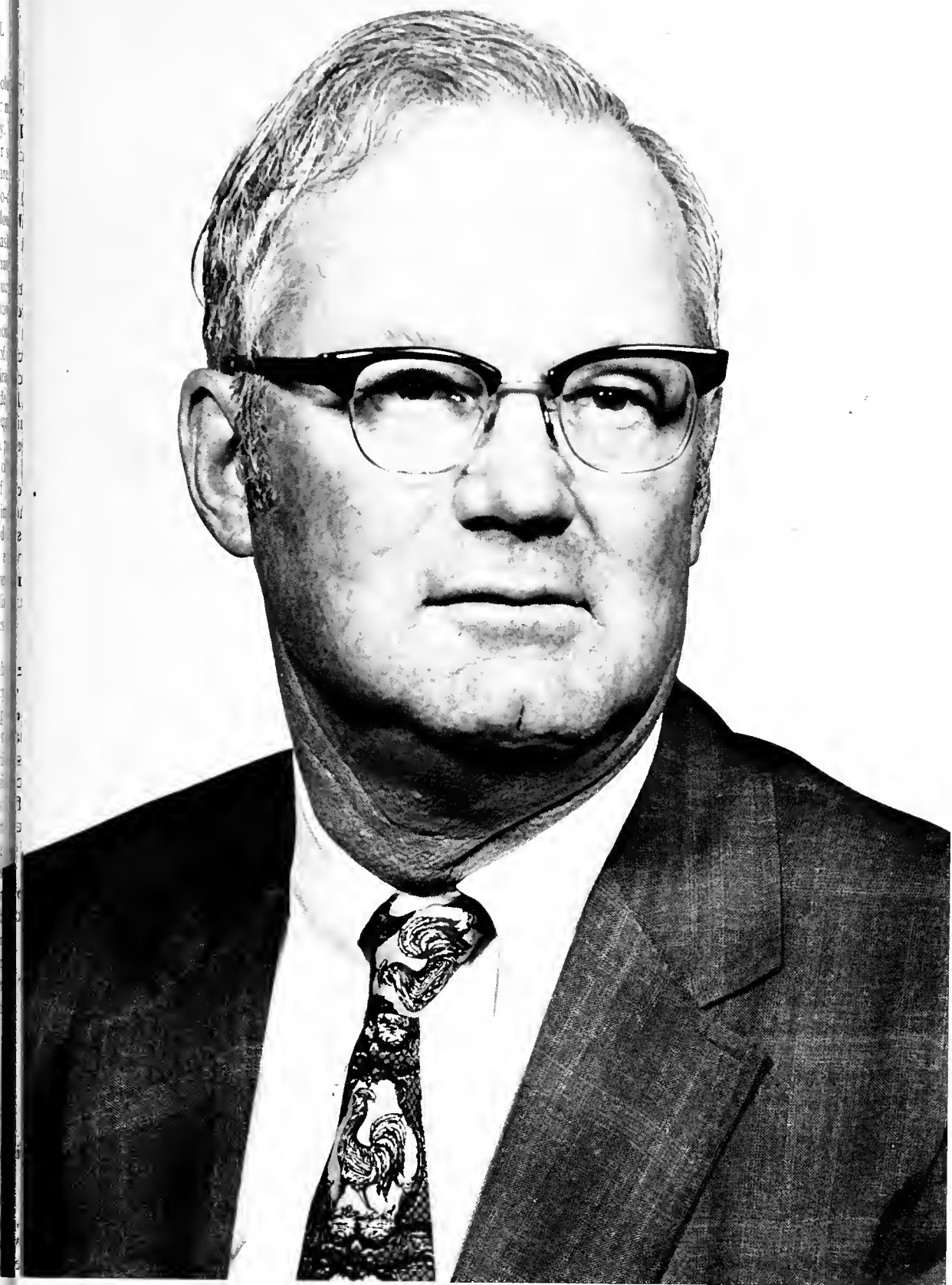
EDDIES: CONTINUING MEDICAL EDUCATION

The 1973 House of Delegates adopted a resolution making continued education a requirement for membership in the North Carolina Medical Society. This will drastically change the pattern of living for some of our members, but I feel that the majority are doing a good job in keeping themselves up-to-date. It has been said that medical information doubles every eight to ten years, so you can see the task we have ahead of us. Many physicians think that the definition of continuing education is a "deductible trip to San Francisco" — but this idea will have to change. The Committee on Continuing Education has recommended that a minimum of fifty hours of continuing medical education each year be required of each member of the State Society, and that wide latitude be allowed in the manner in which the required time is spent. Attendance at scientific meetings, participation in clinical conferences, and perusal of the scientific literature are worthwhile forms of continuing education, and credit will be given for time spent. Each physician will be asked to keep and submit records which will enable him to certify every third year that he has met the minimum requirement of 150 hours. A form for certifying compliance will be included with the annual notice of dues sent to each member.

Continuing education has to be aimed at the individual physician, for his individual deficiency or needs. If it is to be acceptable, good continuing education must ensure better patient care. Ten states including Alabama, have already instigated this requirement. Most of the uneasiness among physicians that arises when this subject is discussed comes from fear of reexamination or relicensure, which certainly is not contemplated. In those states that require continued education, the quality of the programs and the attendance at the state meetings has improved. Maybe our meetings could use just such a "shot to the arm." As we all know, medical education is a lifetime job, and physicians should be given full credit for all the "keeping up" they have done in the past, as well as for the high quality of care that is presently being rendered in our state.

PSRO: TROUBLED WATERS

As all of our members must know, with the continuous pounding of President George Gilbert, Public Law 92-603 was signed into law by President Nixon on October 30, 1972. This law requires a review of every hospital and nursing home patient who comes under the Medicaid or Medicare program, and to accomplish this, professional standard review organizations (PSRO) must be established in every state. This review is to have three parameters — (1



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is it medically necessary? (2) was it given at the appropriate level of care? and, (3) was it of such quality as to meet professionally organized standards? In North Carolina there are eight designated areas, eight separate organizations must be formed. The 1973 House of Delegates, by adopting the report of the Executive Council which established the North Carolina Peer Review Foundation, Inc., went on record as approving professional standard review in the state. The state PSRO organization is actively educating our membership concerning the law. It is also conducting an ongoing review of the Medicaid patients in skilled nursing homes and in psychiatric and TBC hospitals within the state, under a contract with the State Department of Human Resources. It has also applied to become a medical resource center to help other PSROs become functional in North Carolina. I feel that our membership will cooperate with this program, since it is the law of the land; if we do not cooperate, lay personnel will be conducting the so-called peer review. If this is a bad idea, as our colleagues predict, then it will fail on its own merits and not because there was no cooperation by the medical profession. One bright hope is that if effective organized utilization review is being done (as is presently being carried out in most of the hospitals in the state), then their results can be accepted by the PSRO organization. If you do not have effective peer review in your hospitals, it would be in your best interest to see that it is set up.

One difficulty seems to be that the government is interested primarily in cost curtailment, whereas we in the medical profession are interested in quality assessment. As you know, this subject is creating much controversy in the AMA.

HIGHWAY SAFETY: CALMER SEAS

Highway safety in North Carolina has always been of paramount importance to our Society. Our old Committee Advisory to the Department of Motor Vehicles had been changed to the Committee on Traffic Safety; it has worked closely with the State Highway Department and the Legislature in promoting laws for improved highway safety. Passage by the 1974 Legislature of Senate Bill 89, making a blood alcohol level of 0.10 percent, or above, prima facie evidence of driving under the influence, is a great step toward improving highway safety. This bill was actively supported by our Committee, which also supported mandatory seat belt legislation. We all know that the drinking driver (not those who break the speed limit) is the greatest menace on our highways today, causing more than fifty percent of all highway accidents. This law should go a long way in taking the drinking driver off the road.

NATIONAL HEALTH INSURANCE: TURBULENT SEAS

We should watch closely, in the coming year, any legislation promoting national health insurance. This

seems to be a popular subject at present — since this is a year of congressional elections, everyone is jumping to get aboard the bandwagon. President Nixon has already announced his comprehensive health insurance program, financed by mandated employer health insurance plans for the employees. Representative Wilbur Mills has joined forces with Senator Ted Kennedy promoting the Kennedy-Mills Health Insurance bill, financed by a massive four percent increase in the Social Security tax and administered by Social Security as a virtually independent agency. I do not need to tell you that politics makes strange bedfellows. This would take a major step down the road toward complete federal financing and control of all health care in the United States. All of these bills plan to build upon or utilize the previously discussed PSRO concept.

As of now, the AMA-sponsored Mediredit bill seems to be the least objectionable one. We should join in support of this legislation. It appears to be certain that some form of catastrophic insurance will pass; if we are fortunate, since this is a motherhood type bill (wedded motherhood, that is), Congress will stop at this. However, the climate seems right for some type of national health insurance bill. Also, needless to say, this will be quite a busy year on the political front in Washington. It would behoove our membership to keep current on this subject and to support MEDPAC 100 percent.

VIEW FROM THE CAPTAIN'S DECK

Many other concerns will arise but suffice it to say that I have brought up enough subjects for you to mull over in the coming months; I feel certain that you will have some timely suggestions for our fall Committee Conclave.

I do not want to leave you with the idea that all is dark on the horizon and that there are only turbulent waters, because this is certainly not so. My good friend, the late Dr. J. Buren Sidbury of Wilmington, the last pediatrician to be president of our Society, spoke in his 1940 presidential address of the swift approach of socialized medicine. As you can tell from my previous remarks, we are still on the same subject thirty-four years later!³

We in medicine today have more going for us than any other profession. You have heard our AMA President, Dr. Russell Roth, state repeatedly that "more people are receiving more and better medical care from more and better trained physicians in more and better equipped facilities than ever before in history."⁴

I feel that our prestige continues at the top of the professions. The AMA, through its aggressive leadership in fighting the administration and the Cost of Living Council, is held in higher esteem by its members than ever before. Our State Society, through its continued, sound progressive leadership—its dedicated executive director and staff—continues to hold a position of enviable esteem among the leaders of

our state. As Society officers, commissioners and committee members, more physicians are working harder for organized medicine in North Carolina than ever before. My plea to you is to continue the good work, because this is *your* Society. I pledge to you that in the coming year I will do everything in my power to continue to maintain our Society as one in which you can be justifiably proud.

I conclude my message by quoting a paragraph from the late Daddy Ross's 1968 address: "This is a time when the productivity and the complexity of our Society is so enormous that it defies accurate

analysis. The only possible course is to hold on to that which is good, of proven fundamental soundness and to try to build in the light of sane study of the past and sane flexibility of the future."⁵

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Temperament: A peculiar habit of body, of which there are generally reckoned four, viz. the sanguine, the bilious, the melancholic, and the phlegmatic.—*William Buchan: Domestic Medicine, or a Treatise on the Prevention and Cure of Diseases by Regimen and Simple Medicines, etc.*, Richard Folwell, 1799 p. 475.

Certain Ethical Aspects of Biomedical Research: Evolution of Concepts of Ethical Standards

James F. Toole, M.D., LL.B.*

PH THERAPEUTICS, 5,000 years of discovery by trial and error and 200 years of increasing use of the scientific method, is in my opinion humanity's most important accomplishment.¹⁻³ Despite this success, the public has maintained an ambivalent attitude toward medicine. In particular, investigators, the very group who have made these advances, are associated with a Jekyll and Hyde image which hardly engenders trust.

Why has this happened? Perhaps because patients and their families, in their search for cures of diseases, mixed superstition, tradition, magic, fear, and religious belief with their medication. Only in the past 50 years have generous portions of scientific medicine been added to the mixture. Disease, once accepted as the will of God, has been shown to be the result of identifiable natural processes and thus, in many cases, curable. This understanding has come about because innovators and experimentalists have educated practitioners and they, in turn, have educated society. But understanding has removed the mystery, the art has be-

come a craft, the awe has been lost, and the public is making ever increasing demands upon its physicians. Consequently, the physician, traditionally one of the most respected leaders of society, has lost much of his status.

What does this preamble have to do with the ethics of human experimentation? Just this: as long as disease processes are not understood, and as long as there is mystery and fear, physicians can do as they wish, and the distinction between treatment and experimentation need not be made. Furthermore, if no treatment is effective, depending upon the severity of the illness, anything may be worth a try. I am certain that this risk-taking was once accepted by the public; nevertheless, from time immemorial, the investigator has faced an enormous risk when he has tried a new technique. For example, the first codification of principles of medical practice was that of Hammurabi, a statement of rules and regulations governing medical practice in Babylon. This 4,000-year-old precursor of NIH guidelines was probably necessitated by the violation of ethical standards. Whether these stone-etched engravings on a temple pillar were a federal response to public pressure will never be known, but one can be certain that the practitioners of the time were

rendered far more conservative when the penalty for infringement became amputation of the hand.

This federal regulation can be contrasted to the self-regulation of the Hellenic tradition, wherein each physician vowed to the gods, "I will follow that system of regimen which according to my ability and judgment I consider for the benefit of my patients and abstain from whatever is deleterious and mischievous." For 23 centuries this oath has been the ethical creed of the medical profession, embodying ideals of service to the patient and emphasizing the healing power of nature.

Nevertheless, Hippocrates performed research as an incidental part of treatment, certainly without informed consent, and surely not to the benefit of his patient when, in the course of treating a head wound, he repeatedly scratched the cerebral cortex with his fingernail, causing contralateral focal motor seizures. For humanity and science he demonstrated the cross-relationship between hemisphere and body, and he showed that convulsive movements originate from the central nervous system. For Hippocrates' patient, the inducement of seizures was, no doubt, a meddlesome maneuver which would be frowned upon by an intramural research committee of today. Yet, countless observations

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such as this, unrecorded and passed from teacher to pupil, have produced the lore of medicine. This trial and error accumulation of knowledge constitutes the core of rational medical knowledge which we use today.

In addition to the fortuitous accumulation of medical knowledge, we have been handed down results of experimentation; an outstanding example is the work of Edward Jenner.⁴ In the eighteenth century, 2,000 people in London died annually of smallpox. Because Jenner rigorously adhered to the experimental method, he proved that he could prevent smallpox. His published results spread the news and his discovery saved millions of lives. Even though the benefits far exceeded the risks, a committee on human experimentation today would question Jenner's prudence in experimenting with diseases in children, one of whom was his own; I doubt that any man living in the eighteenth century would have done so. Are we creating a climate in which future Jenners cannot develop?

In contrast to Jenner's approach, Beaumont⁵ never planned to do research. Yet this surgeon, stationed at an outlying army post, converted a patient's tragedy into an unequaled experimental opportunity. He assumed risk by deviating from the norms set by the army. Although he was not an academician and his work was not performed in a university setting, his observations opened a new vista in human physiology. In the course of his studies on Alexis St. Martin, Beaumont formulated the first American code of ethics, although personal, for human experimentation. Although he was a member of the regular army (generally a conservative group) Beaumont proposed: (1) that areas of medicine in which human experimentation is necessary and in which the information cannot otherwise be obtained must be recognized, and (2) that the subject's voluntary consent is necessary. With regard to the second criterion, Beaumont bound St. Martin with a contractual arrangement and had him recruited

into the United States Army for one year to:

serve, abide and continue with the said William Beaumont, wherever he shall go or travel or reside in any part of the world his covenant servant and diligently and faithfully, etc., . . . that he, the said Alexis, will at all times during said term when thereto directed or required by said William, submit to assist and promote by all means in his power such philosophical or medical experiments as the said William shall direct or cause to be made on or in the stomach of him, the said Alexis, either through and by means of the aperture or opening thereto in the side of him, the said Alexis, or otherwise, and will obey, suffer and comply with all reasonable and proper orders of or experiments of the said William in relation thereto and in relation to the exhibiting and showing of his said stomach and the powers and properties thereto and of the appurtenances and the powers, properties and situation and state of the contents thereof. The agreement was that he should be paid his board and lodging and \$150 for the year.

By today's standards such a contract would probably be illegal, and in any case, unethical.

Walter Reed, working with the sanction of the Surgeon General of the United States Army, found the cause and the means for the prevention of yellow fever by giving to military volunteers injections of blood from patients who had this disease. Today his methods would not be tolerated by a human experimentation committee, because he took risks with the lives of healthy volunteers. Yet, he received the commendation of the President and Congress for his success.⁶

I mention these several milestones in successful human experimentation, not to participate in historical revisionism à la Soviet, but to develop an historical perspective for the changing concepts of the ethics of human experimentation and to set the stage for the subject of the following discussion — a need for heightened public awareness of the necessity for human experimentation and for a societal acceptance that some risk to individuals is necessarily concomitant.

In a discussion of the ethics of human investigation, it is popular to raise the specter of the German physicians who, under the Nazi regime, performed experiments on unwilling subjects.⁷ However, the conduct of past and present biomedical investigations in Germany and in this coun-

try are not comparable in any way. The German physicians' experiments were, in essence, unethical because unwilling subjects were exposed to high-risk investigations which, in some instances, were uniformly fatal. State-employed physicians worked at the direction of the German government. Their experiments were designed to accumulate information relevant to the German effort. They reported many of the results of experiments at German medical meetings where no ethical objections from the profession were raised. As defendants at Nuremberg⁸ they used the following arguments:

1. They worked under orders of the state.
2. They worked as a part of a total war effort wherein the benefit to society outweighed the harm to condemned individuals.
3. Their work was approved by the community of German physicians and was therefore the ethical norm.
4. Clinical investigators around the world had used captive populations as unwilling or unknowing subjects for research and had published their results without censure. (In the United States the work of Goldberger⁹ of the United States Public Health Service on pellagra, altering diets in prisons and orphanages, was placed in this category.)

Each of these arguments was considered and rejected by the Nuremberg tribunal, the upshot being that medicine has a *worldwide* ethic not limited by national boundaries. This proposal was codified at Helsinki, Finland, by the World Medical Association, and it has been endorsed by most members of the Community of Nations. All United States investigators work within the bounds of this code and those of the American Medical Association,¹⁰ and more recently in U.S.P.H.S. guidelines.¹¹

Why, with all of these safeguards, has society chosen to cast its eye upon clinical research? The reasons involve several factors: (1) the taxpayers' support of our clinical research, (2) the interest in civil rights, from which has developed the patients' bill of rights, (3) the prin-

ple of a right to health, (4) our failure at times to maintain the most exacting standards for the conduct of human experimentation, and (5) our own lack of awareness that there is a problem. For example, of 100,000 articles indexed in medical journals in 1950, none addressed themselves to the ethics of human experimentation, and in 1969 there were only 32 articles, of which most dealt with organ transplantation or brain death. Yet at the same time, ethicists, sociologists, jurists, theologians and philosophers were becoming interested in the field, and with increasing influence they were beginning to publish their views.¹²⁻¹⁴ Over the years their voices have become dominant; with the exceptions of Katz⁷ and Beecher,¹⁰ the medical community has, by and large, remained mute.

Let me illustrate. Today, nearly all clinical research is carried out in the teaching hospital environment. Society perceives that, in this environment, too much emphasis has been placed on science rather than on excellence and the delivery of care. Furthermore, in the "publish or perish" ambiance, the clinician may be under pressure to experiment and therefore may have conflicting goals. Although medical schools can be proud of their record of scientific leadership, their lack of leadership in the development of controls for safeguarding human subjects, and for assuring that therapy is not subverted for research purposes, has led to our present predicament.

A remarkable aspect of the current interest in ethical guidelines is that clinical investigators generally do not accept that regulation is needed. The pressure from the public to define ethical guidelines for human experimentation is expressed through the media¹⁵⁻¹⁷ and more recently by the Congress.¹⁸

This trend was first identified, but poorly expressed, by medical practitioners who muttered about researchers' admitting patients to university hospitals, not for the treatment of the patient's disease, but for a look at his "interesting problem." Patients were minimally aware that

they were being used for experimental purposes; many such patients had a naive trust that physicians would serve them in the best way they knew how, and others who were charity patients had no alternative to submitting to experimental procedures. Owing to the rise of the civil rights movement, the advent of Medicare, and particularly the increasing sophistication of patients regarding good medical practice, society is demanding involvement in the decisions regarding human experimentation. Some members of society assert that biomedical research is too important a responsibility to be given to only the physicians, just as war is too important a responsibility to be given to only the military.

Society's demand for involvement in these decisions is embodied in the Congressional hearings which have been held since 1971, and in the bills now pending. One of the bills, HR 10403 (and parts of 7724), proposes to create a commission of laymen and clinical investigators to devise guidelines for human experimentation. These guidelines, of course, would become legislated ethics if the bill were enacted. This bill represents a departure from the norm, positively suggesting an increasing sense of societal responsibility and, at its worst, bureaucratic restriction of new ideas. It capitalizes, as we in clinical research should have been doing, upon the widespread public interest in the selection of donors for cardiac transplantations; the studies on syphilis which were conducted on Alabama Negroes; the submission of the mentally retarded and prisoners, by their custodians, to experimentation; and, the possible effects of psychosurgery on society.

An unexpected aspect of this interest is that the Congress had incorporated into its bill directives that may prohibit the performance of certain brain operations. Thus, for the first time, we would have regulations which prohibit a specific category of research and treatment, inserting the political element into what has heretofore been a medical responsibility.

Of course, surgical psychiatry has

been practiced since the 1940s, and the Nobel Prize was awarded in 1949 to Egas Moniz,¹⁹ a neurologist, for his research in the use of frontal lobotomy for psychotic states.²⁰ Behavioral control by medication is a daily occurrence practiced by every physician who dispenses psychotropic agents. Current interest in the matter relates primarily to the control of sociopathic and psychotic behavior, and the public is questioning the justification for these procedures. An unexpressed aspect of this doubt is a direct outgrowth of the Soviet's use of insane asylums for the incarceration of political dissidents. This is the fear — that psychosurgical techniques could be manipulated for political ends; that is, if one does not agree with our political philosophy, the state could employ its physicians to alter one's brain in such a way that there would be no alternative.

The Congressional demand for regulation of research is based upon conflict between two competing interests: the improvement of medical care and prevention of disease, and the protection of the rights of the individual. We investigators know that both aims are essential to medical progress. The public must be shown that they are not necessarily mutually exclusive, although they may well prove to be so if legislation is passed without the benefit of thoughtful input from the medical and scientific community. I would advise you to make yourselves familiar with the pending bills and to consider carefully their long-term effects on biomedical research; act through your specialty societies and the Association of American Medical Colleges and the American Medical Association to ensure that appropriate safeguards for the public, which will not jeopardize our proud record of scientific achievement, are enacted into law.

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Reimplantation of Extremities by Microvascular Suture

James G. Boyes, Jr., M.D.

CURRENTLY, our medically sophisticated populace desires surgical replacement of injured or worn organs and limbs. Medical technology has responded with some success to the public demand. Temporarily, there is a growing interest in peripheral microvascular suture as reflected by published medical events. The pinnacle of microvascular anastomoses has occurred with some frequent successful restoration of upper extremity severances.

HISTORICAL PERSPECTIVE

Whereas American Civil War surgeons proved to be masters at amputation for gangrenous limb parts, military and civilian surgeons since the Korean War have emphasized reconstructive techniques. Their contributions were inspired by innovative surgeons using animal experimentation at the turn of the century.

In 1903 Hoepfner¹ first attempted reimplantation of completely severed limbs in dogs. Carrel and Guthrie,² in 1906, reported the reimplantation of a canine leg amputated at mid-thigh; the dog survived vascular anastomosis but succumbed to sepsis. Carrel,³ in

1908, reporting upon his "Results of Transplantation of Blood Vessels, Organs, and Limbs," described the transplant performed in April 1907 of a "fresh cadaver dog thigh to a white bitch with resuture of femoral vessels and limb parts completed in three hours and ten minutes." This animal succumbed to an abscess on the tenth day but with an otherwise viable extremity. The following year Carrel,⁴ using more careful aseptic techniques, completed "his first experimental grafting" of a male fox terrier below knee limb to a female fox terrier. Halsted,⁵ in 1924, reported that "thirty-five years ago (in 1887) in the laboratory of Dr. Welch, Dr. Halsted successfully transplanted the hind leg of a dog from one side to the other, leaving however, the main artery intact a few days, until union between the muscles and other divided tissues had taken place." Halsted related also that on June 6, 1921, a canine hind leg was transplanted successfully despite the presence of a vessel surgically occluded seven months previously by Dr. Bidgood and Reichert.

From Alexis Carrel's studies were formulated the principles for anastomosis — namely, hemostasis with non-crushing clamps; adequate preparation of vessel ends; the

placement of triangular stay sutures; and the closure of the triangulated vessel with running everted sutures.

From 1953 to the present the surge of interest and development has compounded. The principles of vascular surgery were explored extensively during the Korean War.⁶ Techniques of small arterial anastomosis, use of vein grafts, and control of postoperative thrombus formation were refined.⁷⁻⁹ Perhaps the greatest impetus to successful small vessel suture was contributed by Jacobson and Suarez^{10, 11} with the development of the Zeiss operating microscope and his design of surgical instruments in 1959.

Malt and McKahnn,¹² of Boston, reported in the *JAMA* the first successful reimplantation of a human upper extremity severed at the mid-arm in 1962. Although the humeral shaft was shortened to achieve reimplantation, some residual neurological defect remained. Following this event was a series of reports of successful reimplantations using comparable techniques. In 1971, Engber and Hardin¹³ recorded 32 cases of upper limb reimplantations, with eight failures occurring from tissue anoxia.

Kleinert, Kasdan and Romero,¹⁴ in 1963, reported four devascularized upper extremities, from the up-

Reprint requests to Dr. Boyes, Suite 310, 928 Randolph Road, Charlotte, North Carolina 28207.

per forearm to the proximal hand, that were successfully restored with skeletal fixation, gentle handling, atraumatic clamps, and atraumatic 6-0 nylon suture. Douglas and Foster¹⁵ reported successful reimplantation of human terminal digit grafts and demonstrated, in 1963, reconstitution of non-sutured vessels in 27 Rhesus monkeys by careful coaptation of skin only at the proximal phalangeal level. Difficulties of reimplantation of vessels gave birth to appliances such as conformers, cuffs, stapling instruments, adherents, and more refined suture material.^{16, 17} In 1963, Lapchinsky of Russia devised a machine that was superior to suture for vessel anastomosis of 2.3 mm diameter.

In 1965, Buncke and Schultz,¹⁸ using the Zeiss operating microscope, fine nylon suture, and clothespin clamps, attempted ten monkey digital amputations and reimplantations before achieving their first survival. In spite of early failure, each attempt improved technique, suture, instrumentation and after-care. Later, their mastery allowed them to reimplant the rabbit's ear.¹⁹ Finally, an immediate Nicoladoni²⁰ procedure (hallux to hand) was successfully performed in a monkey using microminiature anastomotic technique.²¹

While the Chinese were reporting successful extremity reimplants,²²⁻²⁵ Herbsman,²⁶ in the United States, reported in 1966 a three-year follow-up of a transcarpal reimplantation. Smith²⁷ reaffirmed the practicality of the microscope for neural as well as vascular suture. Cobbett,²⁸ while a registrar at Queen Victoria Hospital, England, culled a vast bibliography of vascular literature to 1967, and in addition, gained sufficient experience to perform a "free digital transfer"²⁹ from a human toe to a thumb (1968).²⁹ Concurrently, the Japanese team of Komatsu, Shigo, Tanai, and Susumu³⁰ successfully reimplanted a completely sectioned thumb.

Lendvey³¹ in Australia, in 1968, reported a successful thumb amputation-reimplantation. The following year he repeated his success with a

completely severed fifth finger using 8-0 monofilament nylon upon a 1-mm heparinized vessel.³²

Kutz, Hay and Kleinert,³³ in 1969, reported on an accumulated 102 patients with 119 arterial injuries. Their results, evaluated by pulse, claudication, Allen's test, and arteriography in some patients indicated an arterial patency rate of 52 percent, with slightly higher results in a forearm vessel. The Chinese²⁵ results as reviewed by Horn²² in the same year indicate that after 20 failures, there were 24 successful digital reattachments in 34 attempts.

In 1970, O'Brien,³⁴ using a Zeiss Triplescope and fine suture technique, achieved an arterial patency rate of 81 percent and a venous patency rate of 90 percent in fifty-eight 1-mm femoral vessels in rabbits. Baxter,³⁵ a fellow investigator, then reviewed the cause of surgical failure histopathologically and found arterial endothelialization to occur between eight and 12 days. Most recently, O'Brien and Miller³⁶ reported and portrayed dramatic success in eight patients with traumatic complete amputations in one or more digits. In 1972, the Japanese group of Tamai⁴⁷ reported four successful digital reimplantations since 1965 using variations of what now appears to be a "standard technique."

CURRENT PERSPECTIVE

Inspired by recent events, surgical teams in large centers throughout the United States are prepared to attempt restoration of dismembered upper extremities. Suture manufacturers are able to produce sutures of 1.0 mils diameter with equally fine needles. Military air evacuation teams are now available for rapid transport. Optical manufacturers are offering 4.5X focal telescoping magnification in eye glasses.

Currently, a cleanly severed or crush injury of moderate severity to a hand part has a reasonable (better than 50 percent) chance of reimplantation under the following conditions:

1. Transport of the patient and specimen within 12 hours—liquefaction necrosis of muscle occurs

when devitalized beyond 12 hours.

2. An experienced operating team with binocular diploscope prepared for a four to eight-hour stay.

3. Adequate surgical instruments.

4. Fine nylon suture 9-0 or 10-0 size.

5. Heparin (1:10,000 units) for both local and systemic purposes.

6. Peripheral dilatation by brachial plexus block together with general anesthesia.

7. Adequate preparation of the amputated stump. Transport should be at 4 C. the stump double-wrapped dry in plastic bags to prevent direct contact of the specimen with ice chips.

At reimplantation, the proximal stump is debrided and the bony skeleton shortened and fixed with intramedullary pins. The separated part, immersed in cold saline or Ringer's solution, is flushed with heparin. The arterial ends for anastomosis, being adequately clamped, are freshened after the adventitia has been stripped back. The vessels are distended with heparin, and magnesium sulphate solution is applied locally. Interrupted fine monofilament nylon suture is placed circumferentially about the vessel. Saran WrapTM, temporarily wrapped about the juncture site after clamp removal, is reported to facilitate sealing leaks.³⁸ The veins are sutured comparably. Papaverine or chlorpromazine 0.25 mg/ml has been applied to overcome spasm.

Once vascular continuity has been established, a single digital nerve and the extensor tendon is sutured. Systemic antibiotic, 6 percent dextran 40 (Rheomacrodex[®]), and systemic heparin (25,000 units per liter of saline) have been used routinely postoperatively. Finally, a two-stage flexor tendon grafting using silicone rods completes the restoration.

CONCLUSION

Although the composite graft of an amputated terminal phalanx survives with simple skin closure alone, restorations at more proximal skeletal levels demand more precise technique and equipment.

Currently, of some 219 vascular

nastomoses of separated hand parts, 105 reimplants have survived. After a decade of international microsurgical trials and triumphs, the reconstruction of vessels as small as .0 mm by microsuture has become reality.

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Editorials

MEDICAL EVALUATION FOR DRIVER LICENSING

Whereas the automobile is a product of a technological triumph and cause of a revolution in mobility, it has at the same time proved to be a health hazard of critical proportions. During the past five years, North Carolina has had an annual average of 126,396 motor vehicle accidents, resulting in an average of 1,853 fatalities, 63,219 injuries, and millions of dollars in property damage, loss of wages, and costs arising from deaths and injuries. Experts in the field of driver medical evaluation believe that drivers' impairment resulting from chronic medical problems, other than alcoholism, is a contributing factor in 15 to 25 percent of automobile crashes. Alcohol is the largest single factor leading to fatalities in automobile crashes.

Although the great majority of people having acute or chronic illnesses drive safely, driving is contraindicated, either temporarily or permanently, for some of these people who have such conditions as uncontrolled epilepsy and diabetes, severe vision problems, certain vascular diseases, neurological disorders, orthopedic diseases and some forms of mental illness. The single medical condition of greatest importance in highway safety, however, is the abuse of alcohol. During the four-year period (from 1970-1973), the Office of the Chief Medical Examiner analyzed the bloods of 2,944 operators and pedestrians killed on North Carolina highways and found that more than 48 percent were under the influence of intoxicating liquor, and another eight percent had been drinking.

In an attempt to aid in the prevention of highway deaths and injuries, the Medical Society, working with the North Carolina Department of Motor Vehicles, established in 1964 a program to medically evaluate drivers. In brief, the program operates as follows: Drivers suspected of having a pertinent medical condition are referred for evaluation by driver license examiners, law enforcement officers, court officials or physicians. The driver is asked to have the physician of his choice complete a medical report form which is sent by the physician to the Department of Motor Vehicles. The report is screened at the Division of Health Services by a physician and, if necessary, additional medical information is obtained. The case may then be reviewed by a panel of three practicing physicians (there are 36 physicians recruited by the Medical Society Com-

mittee Advisory to the Department of Motor Vehicles serving on these panels). The panel reviewing a case recommends approval of the person's driving privilege; approval with certain restrictions, such as a 45 mph speed limit, or daylight driving only; or disapproval. Panel members review each case independently, and the recommendation to the Department of Motor Vehicles is based on the summation of the three recommendations. The AMA pamphlet *Physician's Guide for Determining Driver Limitation* and the U.S. Public Health Service pamphlet *Driver Guidelines for Medical Advisory Boards* are used by the panelists as general guides in furnishing their opinions.

A person whose driving privilege has been disapproved by the panel can appeal his or her case to a medical review board. Three sections of the board, each consisting of a minimum of two physicians appointed by the President of the Commission for Health Services, and a representative appointed by the Commissioner of Motor Vehicles, meet monthly in Raleigh to hear these appeals, and the person whose license has been denied appears before the board. The board has authority to restore, restrict or continue the denial of driving privileges, and its decisions are binding on the Commissioner of Motor Vehicles. Actions of the board, however, are subject to judicial review.

What is the Driver Medical Evaluation Program accomplishing? Its goal is to reduce accidents by either removing from the highways those drivers who are medically unfit to drive or by restricting to reduced speeds, daylight driving only, and similar limitations, drivers who have lesser degrees of medical impairment. During 1973, the program evaluated 9,784 drivers and driver license applicants. In a sizeable number of the cases evaluated it was obvious that the person's medical condition would interfere with driving; but a large percentage of cases are not so obvious. Approximately ten percent of the people reviewed in 1973 were disapproved for medical reasons, and an additional 25 percent were given restricted driving privileges. One must always keep in mind that removal or even restrictions of a person's driving privilege may seriously interfere with his or her livelihood. This factor must be balanced against the danger inherent in the decision to permit a medically unqualified driver to continue driving. Such decisions are very often not easy to make. Taking away the drinking driver's license is also ar

New York is a vertigo festival.

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Antivert[®] (meclizine HCl) has been found useful in the management of vertigo associated with diseases affecting the vestibular system. It is available as Antivert/25 (25 mg. meclizine HCl) and Antivert (12.5 mg. meclizine HCl) scored tablets for convenience and flexibility of dosage. Antivert/25 (25 mg. meclizine HCl) Chewable Tablets are available for the management of nausea, vomiting, and dizziness associated with motion sickness.

BRIEF SUMMARY OF PRESCRIBING INFORMATION

***INDICATIONS.** Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, FDA has classified the indications as follows:

Effective: Management of nausea and vomiting and dizziness associated with motion sickness.

Possibly Effective: Management of vertigo associated with diseases affecting the vestibular system.

Final classification of the less than effective indications requires further investigation.

CONTRAINDICATIONS. Administration of Antivert during pregnancy or to women who may become pregnant is contraindicated in view of the teratogenic effect of the drug in rats.

The administration of meclizine to pregnant rats during the 12-15 day of gestation has produced cleft palate in the offspring. Limited studies using doses of over 100 mg./kg./day in rabbits and 10 mg./kg./day in pigs and monkeys did not show cleft palate. Congeners of meclizine have caused cleft palate in species other than the rat.

Meclizine HCl is contraindicated in individuals who have shown a previous hypersensitivity to it.

WARNINGS. Since drowsiness may, on occasion, occur with use of this drug, patients should be warned of this possibility and cautioned against driving a car or operating dangerous machinery.

Usage in Children: Clinical studies establishing safety and effectiveness in children have not been done; therefore, usage is not recommended in the pediatric age group.

Usage in Pregnancy: See "Contraindications."

ADVERSE REACTIONS. Drowsiness, dry mouth and, on rare occasions, blurred vision have been reported.

More detailed professional information available on request.

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inadequate solution since alcoholics, probably more than any other group of people with medical problems, often continue drinking and driving whether or not they have a driver's license. A combined law enforcement and treatment program might be the answer to the problem of these potentially dangerous drivers and their potential victims.

As of January 1, 1974, there were more than 3,300,000 licensed drivers in North Carolina. Of these, the following had one or more convictions for driving while intoxicated: 136,280—one conviction; 36,850—two convictions; 14,300—three convictions; 4,840—four convictions; 1,700—five convictions; and 960 had more than five convictions.

During the four-year period (from 1970-1973), 28,744 medical reports were reviewed for drivers licensing purposes and of these, 8,767 were for alcohol-related instances of abuse or illness. More than 30 percent of the drivers being medically evaluated, therefore, are reviewed as a result of alcohol abuse.

The physician should consider it his professional responsibility to advise and counsel his patient whom he feels would be unsafe, or a hazard to himself or others, as a driver of a vehicle. He should be alert to warn his patient of any physical condition (diabetes, epilepsy, CVA, heart disease and other medical problems) which would restrict or affect the patient's driving ability. It would be advisable that the physician give positive instructions on when to drive and when not to drive, driving and rest periods, speeds, and whether to avoid rush hours or nighttime driving. When the physician is presented with a medical report for driver medical evaluation, he should include all the necessary information, re-

gardless of how minor it might seem. It is important to the panel that they review all facts in order to make an adequate appraisal of the driver.

Information provided on the medical reports is treated in a confidential manner and is not released to the driver license applicant or to any other unauthorized person. The examining physician is always in the best position to determine a person's fitness to operate a motor vehicle safely. The examining physician's recommendation, therefore, is extremely valuable. Accurate and essential medical information acts as a safeguard against licensing potentially dangerous drivers, on one hand, and needlessly removing the opportunity of the citizen to drive, on the other. When a physician considers that it would be hazardous for a patient to continue driving, he may report the patient's name and address to the Medical Advisor, Driver Medical Evaluation, Division of Health Services, Post Office Box 2091, Raleigh 27602. Action will then be initiated by the Medical Advisor to have the patient evaluated for driver licensing purposes.

Identifying the impaired driver and compensating for his physical and mental conditions continue to be problems of major proportions. The ultimate solution will unquestionably reduce traffic fatalities. This program is steadily progressing, and the medical profession is exerting a profound influence in the reductions of injuries and highway deaths.

FRED G. PATTERSON, M.D.
Medical Advisor
Driver Medical Evaluation Program
Division of Health Services
North Carolina Division of Human Resources

Emergency Medical Services



ORGANIZING AND ESTABLISHING A RURAL EMERGENCY MEDICAL SYSTEM

Bond L. Bible, Ph.D.
Secretary

AMA Council on Rural Health

Emergency Medical Service Councils, if organized, could initiate planning, education and funding activities for large service areas in rural regions. This was recently suggested by Dr. John Wiggstein, a member of the AMA's Committee on Community Emergency Services. There should be some attempt to collect data regarding emergency medical transportation, communication and facilities for the rural

area. Following this, an Emergency Medical Service Council could be formed consisting of providers of health services, public agencies involved in health care, community leaders, and perhaps the news media.

Funding for activities could be obtained from local municipal or private funds, the Comprehensive Health Planning Agency or federally appropriated funds. The funds should be used to support work in personnel and training, transportation, health care facilities, communication and public relations.

Dr. Julian A. Waller of the University of Vermont, at a recent national conference on rural health, suggested that these councils should not be merely

miniaturized versions of cities and suburbs. He suggested that the following be considered:

Two-way radio between ambulances and hospital.

Nurses or Physician's Assistants properly trained and in the emergency room 24 hours a day.

Careful plans to cover emergency activity while the physician is enroute to the hospital.

A physician trained in emergency medicine on call and available within 15 minutes.

Proper signs on highways and in the community to the treatment facility and emergency care center.

Dr. Waller also suggested that the Emergency Medical Service councils could work closely with the administrative and medical staff of their local hospital to coordinate relations and procedures with police and ambulance services on their role in community safety and health education.

For further information on EMS Councils and programs, write for "Developing Emergency Medical Services—Guidelines for Community Councils," Commission on Emergency Medical Service, American Medical Association, 535 North Dearborn Street, Chicago, Illinois 60610.

—Abstracted by GEORGE JOHNSON, JR., M.D.

From "Emergency Medicine Today" AMA Commission on Emergency Medical Services, Volume 3, No. 6, John M. Howard, M.D., Editor, Original article can be obtained from the American Medical Association, 535 North Dearborn Street, Chicago, Illinois 60610.

Committees and Organizations

COMMITTEE ON MEDICAL EDUCATION

Research Triangle Park, Feb. 21, 1974

The following recommendation was adopted:

Whereas, the Committee on Medical Education of the North Carolina Medical Society is convinced of the potential which Area Health Education Centers (AHECs) have for increasing continuing educational opportunities for physicians, nurses, and allied health personnel in North Carolina, and

Whereas, the Area Health Education Centers program will increase the number of physicians and im-

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prove the quality of medical care in North Carolina, and

Whereas, the Committee feels that AHECs provide the most economically feasible program for improvement of health care needs in North Carolina, therefore

Be it Resolved, that the Committee on Medical Education of the North Carolina Medical Society reaffirms its support of the continued development of Area Health Education Centers throughout the State of North Carolina.

RICHARD H. AMES, M.D., *Chairman*

Bulletin Board

NEW MEMBERS of the State Society

Allen, James Lathan, M.D. (OBG), 1821 Green St., Durham 27705

Averill, John Bradley, M.D., Meadow Park Dr., Drawer 1, Tryon 28782

Bevis, Charles Alan, M.D. (ORS), 2709 Ellerbe St., Winston-Salem 27103

Bombatepe, Vamik, M.D. (GP), 204 N. Herman St., Goldsboro 27530

Clark, Richard Lee, M.D. (DR), 602 Emory Dr., Chapel Hill 27514

Cunningham, Jerome James, M.D. (R), Bowman Gray, Winston-Salem 27103

Dillon, Robert Gwyn, M.D. (IM), 912 Carolyn St., Statesville 28677

Dunphy, Donal Leo, M.D. (PD), 517 Red Bud Road, Chapel Hill 27514

Eaton, Hubert Arthur, Jr., M.D. (IM), 411 N. 7th St., Wilmington 28401

Gibson, Noah Francis, IV, M.D. (Intern-Resident), 920 Knollwood St., Winston-Salem 27103

Grant, Paul Joseph, M.D. (Intern-Resident), Box 121, N. C. Baptist Hospital, Winston-Salem 27103

Grisham, Joe Wheeler, M.D. (PTH), 1703 Curtis Road, Chapel Hill 27514

Hammer, Donald Edwin, M.D. (GS), 2206 Cumberland Ave., Charlotte 28203

McLelland, Robert, M.D. (R), Box 3808, Duke Med. Ctr., Durham 27710

Nichols, George Louis, M.D. (P), 1431 Laurel Lane, Gastonia 28052

Redick, Lloyd Franklin, M.D. (AN), Box 3094, Duke Med. Ctr., Durham 27710

Reid, Richard Alton, M.D. (PUD), 1404 Seminole Dr., Greensboro 27401

Wallace, Raymond Dewey, Jr., M.D. (FP), 127 Main St., Box 36, Hudson 28638

Waller, Ted James, M.D. (ORS), University Village, Boone 28607

Wyman, John Sheldon, M.D., 1810 Country Club Rd., Hendersonville 28739

WHAT? WHEN? WHERE?

In Continuing Education

August 1974

("Place" and "sponsor" are listed only where these differ from the place and group or institution listed under "for information.")

In North Carolina

September 6-7

Symposium on Arthritis

Place: Babcock Auditorium

Fee: \$30.00

For Information: Emery C. Miller, M.D., Associate Director for Continuing Education, Bowman Gray School of Medicine, Winston-Salem 27103

September 6-7

Annual Meeting of the North Carolina Chapter of the American Academy of Pediatrics and the North Carolina Pediatric Society

Place: Pinehurst Hotel and Country Club, Pinehurst

For Information: Mrs. John McLain, Executive Secretary, 3209 Rugby Road, Durham 27707

September 13

Pathology and Treatment of Conditions Affecting the Knee Joint. This is a one day course designed for rehabilitation nurses, insurance carriers and members of the Industrial Accident Commission of N. C.

Sponsor: Division of Orthopaedic Surgery, Department of Surgery

For Information: Frank H. Bassett, III, M.D., Box 291, Duke University Medical Center, Durham 27710

September 18-19

19th Annual Angus M. McBryde Perinatal Symposium

Fee: \$50.00

For Information: George Brumley, M.D., Division of Perinatal Medicine, P. O. Box 2911, Duke University Medical Center, Durham 27710

September 19-21

Topics in Internal Medicine, the Fourth Annual Seminar in Medicine

Place: Babcock Auditorium

Fee: \$75.00

For Information: Emery C. Miller, M.D., Associate Director

The case of the motorcycle rider who was quickly cast in a new role.



James McWillis of Winston-Salem. Fourth in a series of actual case histories from the files of Blue Cross and Blue Shield of North Carolina.

The man with the plaster arm is James McWillis of Winston-Salem—an ardent cyclist who had an accident trying to avoid an accident. It happened at Myrtle Beach. While swerving to miss a car, his motorcycle overturned, he broke his arm and sprained both ankles.

James was rushed to a hospital. They x-rayed his arm, put the cast on, and taped his ankles—all in the Outpatient Department. After he got back home, his doctor sent him to the hospital for more X rays to see if his arm was healing properly. And they were also made as a hospital outpatient.

The accident was unfortunate. But James was lucky in one way. He's a member of a Blue Cross and Blue Shield group plan paid for by his employer. It covers outpatient treatments like X rays and casts. So at least he wasn't hobbled with hospital

bills. He's back at work now, at the Reynolds Division of the Forsyth County Hospital Authority, Inc.

Outpatient benefits are just one example of the broad coverage provided by Blue Cross and Blue Shield of North Carolina. In addition to basic inpatient care, these extra benefits include visiting nurse service, skilled nursing facility care, and the services of home health agencies. And all are available on a group or non-group basis. Blue Cross and Blue Shield of North Carolina—a good influence on everybody's health.

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This advertisement appeared in North Carolina newspapers.

for Continuing Education, Bowman Gray School of Medicine, Winston-Salem 27103

September 20-21

1974 Walter L. Thomas Symposium on Gynecologic Malignancy and Surgery

Program: The two day symposium will be clinically oriented with the main emphasis on "Ovarian Cancer" and "Difficult Office Gynecology." Invited guest speakers include Herbert Buchsbaum, Iowa City, Iowa, and Dr. J. Taylor Wharton, Houston, Texas.

Credit: AAFP credit applied for.

For Information: W. T. Creasman, M.D., Director of Gynecologic Oncology, P. O. Box 2079, Duke University Medical Center, Durham 27710

September 25-28

North Carolina Medical Society Annual Committee Conclave

Place: Mid-Pines Club, Southern Pines

Regular meetings will be scheduled for the chairmen and members of almost all regular committees of the Medical Society. Committee members should plan to be present if at all possible.

For Information: Mr. William N. Hilliard, Executive Director, North Carolina Medical Society, P. O. Box 27167, Raleigh 27611

September 27-29

Invitational Assembly for Advanced Urology-Urinary Calculi and Related Diseases

Place: Pinehurst Hotel and Country Club, Pinehurst

Fee: \$100

For Information: James F. Glen, M.D., Box 3707, Duke University Medical Center, Durham 27710

October 2-3

Fourteenth Annual Charlotte Postgraduate Seminar

Place: Charlotte Memorial Hospital Auditorium

Sponsor: Mecklenburg County Chapter American Academy Family Physicians

Program: Topics will include acute leukemia and solid tumors in children, acute myocardial infarction, difficult EKGs, oral contraception in the female, perimenopausal problems, respiratory emergencies, infectious diseases and difficult lung diseases. Spouses of participants are invited to attend Dr. Gordon Deckert's Wednesday afternoon session, Transactional Analysis, Concepts, and Sex.

For Information: Mrs. Farrior Harloe, 1336 Brockton Lane, Charlotte 28211

October 4

Forsyth County Heart Association

Place: Babcock Auditorium, Bowman Gray School of Medicine, Winston-Salem

Fee: \$15.00

For Information: Mrs. Katherine Cox, Forsyth County Heart Association, 2046 Queen Street, Winston-Salem 27103

October 20-22

Annual Joint Meeting of the North Carolina-South Carolina Societies of Ophthalmology and Otolaryngology

Place: Asheville Hilton Inn, Asheville

Sponsor: The North Carolina Society of Ophthalmology and Otolaryngology

For Information: Banks Anderson, Jr., M.D., Secretary-Treasurer, P. O. Box 3802, Duke University Eye Center, Durham 27710

October 28-November 1

Radiology Postgraduate Course

Place: Southampton Princess Hotel, Southampton, Bermuda

Program Chairman: Richard G. Lester, M.D., Professor and Chairman of Radiology, Duke University Medical Center.

Guest speakers will include: Robert G. Fraser, M.D., Professor and Chairman of Radiology, McGill University Medical School, Montreal, Canada; John A. Evans, M.D., Professor and Chairman of Radiology, Cornell University Medical College; William B. Seaman, M.D., Professor and Chairman of Radiology, Columbia University College of Physicians and Surgeons, New York, N. Y.; Harold G. Jacobson, M.D., Professor and Chairman of Radiology,

Albert Einstein College of Medicine (MHMC), Bronx, New York; and David H. Baker, M.D., Director, Radiology, Babies Hospital, Professor of Radiology, Columbia University College of Physicians and Surgeons, New York, N. Y. Subject matter will cover Pediatric and Adult Radiology of the Chest, Genito-Urinary Tract, Gastrointestinal Tract and Musculo-Skeletal System.

Fee: \$200

Credit: Twenty-three hours AMA "Category One" accreditation

For Information: Robert McLelland, M.D., Department of Radiology, Box 3808, Duke University Medical Center, Durham 27710.

November 4-6

Amputations and Prosthetics

Place: Holiday Inn West, Durham

Sponsor: American Academy of Orthopaedic Surgeons, Chicago, Illinois

Fee: \$150

For Information: Frank W. Clippinger, M.D., Box 29, Duke University Medical Center, Durham 27710

November 15-16

Anesthesiology Fall Seminar

Place: Charlotte Memorial Hospital Auditorium

Fee: \$40.00

For Information: Dr. H. A. Ferrari, Chairman, Department of Anesthesiology, Charlotte Memorial Hospital, P. O. Box 2554, Charlotte 28201

December 6-7

What's New in Newborn Care?

Place: Babcock Auditorium

Fee: \$45.00

For Information: Emery C. Miller, M.D., Associate Director for Continuing Education, Bowman Gray School of Medicine, Winston-Salem 27103

New Directory Available

The second edition (OP-414) of the *Directory of Self-Assessment Programs for Physicians* is now available for \$1.00 from the Order Department, American Medical Association, 535 N. Dearborn, Chicago, Illinois 60610. The new edition lists six new self-assessment programs in: Allergy, Cardiology, Chest Diseases, Colorectal & Anorectal Surgery, Emergency Medicine, and Neurological Surgery. A total of 21 programs is sponsored by specialty societies, a county medical society and one university. Each program, listed by topic and sponsor, is described with regard to intended participant, sites and time of testing, dates of last test and most recent revision, objectives and content, format, time required, method of scoring, aids to learning provided, fees charged and where to write for further information.

Cancer Information by Phone

A toll free phone call to The Southern Medical Association Cancer Education Service (1-800-231-6970), makes cancer information available by phone to physicians in North Carolina and other states in the Southern Medical Association area. Tapes must be requested by number. For a cross-indexed list of over 260 tapes call the above number, identify yourself by name, address, city and state, and request a copy of the index.

In Contiguous States

August 19-22

Recent Advances in Allergy: daily seminars, 8:00 a.m. to 10:00 a.m.

Place: The Homestead, Hot Springs, Virginia

For Information: Claude A. Frazier, M.D., 4-C Doctors Park, Asheville, North Carolina 28801

September 9-11

A Symposium on Cardiovascular Nursing

Place: University of Tennessee, 323 McLemore Street, Nashville, Tennessee

Sponsors: The American College of Cardiology, The Cardio-

vascular Education Program, and the University of Tennessee at Nashville
e: \$100
edit: Accredited by the State Board of Education in Maryland
rogram: Designed for the experienced cardiovascular nurse. Highlights electrocardiography with particular reference to electrophysiology and interpretation of both rhythm and contour.
r Information: Miss Mary Anne McInerney, Director, Department of Continuing Education Programs, American College of Cardiology, 9650 Rockville Pike, Bethesda, Maryland 20014.

September 16-21

th Annual Family Practice Refresher Course
ce: Mills Hyatt House Hotel
e: \$140.00 payable in advance on or before September 1. Enrollment limited to 75 persons.
edit: Forty hours AAFP credit approved.
e registration fee includes the Social Hour and Banquet on Wednesday evening. Wives are cordially invited.
r Information: Vince Moseley, M.D., Director, Division of Continuing Education, Medical University of South Carolina, 80 Barre Street, Charleston, S. C. 29401

September 30 & October 1

ennessee Valley Medical Assembly annual meeting
- Information: Thomas L. Buttram, M.D., Chairman, Tennessee Valley Medical Assembly, Whitehall Medical Center, 960 E. Third Street, Chattanooga, Tennessee 37403

October 5-8

thern Psychiatric Association annual meeting
ce: The Homestead, Hot Springs, Virginia
- Information: Mrs. Annette Boutwell, P. O. Box 10387, Raleigh 27605

ns submitted for listing should be sent to: WHAT? WHEN? WHERE?, P. O. Box 8248, Durham, N. C. 27704, by the 10th of the month prior to the month in which they are to appear.

News Notes from the—

UNIVERSITY OF NORTH CAROLINA DIVISION OF HEALTH AFFAIRS

Dr. Raymond P. White, Jr., of Virginia Commonwealth University was appointed dean of the School of Dentistry and professor of oral surgery at UNC-Chapel Hill, effective July 1. Dr. White succeeds Dr. James W. Bawden, who will return to teaching and research.

The Rev. Philip Washburn was commencement speaker for 124 graduating students in the School of Dentistry on May 12. During the special graduation program, 59 doctor of dental surgery candidates wore hooded, and 60 bachelor of science degrees and certificates in dental hygiene and five bachelor of science degrees in dental auxiliary teacher education were awarded.

Mary C. George was appointed director of the Dental Auxiliary Teacher Education (DATE) Program in the Department of Dental Ecology at the School of Dentistry, effective July 1. Mrs. George succeeds Alberta Beat Dolan who directed the program since its beginning in 1968.

Charles G. Shea has been appointed assistant pro-

fessor in the Department of Oral Surgery. He holds the B.S. and D.M.D. degrees from the University of Pittsburgh.

Eugene F. Howden has been promoted to associate professor in the Department of Pedodontics.

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The UNC School of Medicine is one of nine medical centers in the United States chosen to study the membrane oxygenator and the effects of its prolonged use. The purpose of the \$330,000 study is to identify the best patient population for extended use of the machine — from 10-14 days. Dr. Herbert Proctor, chief investigator and head of the trauma section in the Department of Surgery, and Drs. Noel McDevitt and Peter Starek will study the results.

A \$436,310 HEW grant to assist the family practice residency program has been awarded to the Department of Family Medicine at the UNC School of Medicine. Dr. Robert Smith, chairman of the Department, said the federal grant is their first.

A \$142,414 grant from the National Heart and Lung Institute to study pulmonary circulation in patients undergoing open heart surgery has been awarded to a team of surgeons at the UNC School of Medicine. Dr. Benson R. Wilcox, chief of the division of thoracic and cardiovascular surgery, will be assisted in the project by Drs. Norman A. Coulter, Jr., Carol Lucas, Gordon F. Murray and David Downie.

The National Cancer Institute has awarded UNC-Chapel Hill \$137,202 to continue studies of specific genes believed to predispose human beings to leukemia and certain cancers. A group of researchers, under the direction of Dr. Michael Swift, hope to show how specific genes increase the probability of malignancies in their carriers. Dr. Swift is chief of the Division of Medical Genetics in the UNC Department of Medicine and a research scientist in the Child Development Institute's Biological Sciences Research Center.

Under a five-year \$235,699 research grant from the National Heart and Lung Institute, Dr. Henry S. Kingdon and his research associate, Dr. Gilbert White, will study the chemical changes that take place in the blood when it clots. Dr. Kingdon is professor of medicine and biochemistry at the UNC School of Medicine and professor of oral biology in the department of periodontics at the UNC School of Dentistry.

A team of scientists at the UNC School of Medicine is trying to discover whether the body's natural immune response to disease can be manipulated to fight cancer. The research program — a collaborative effort between the departments of surgery and bacteriology and immunology—is funded by a \$914,979 grant from the National Cancer Institute. The research will be under the general direction of Dr. Geoffrey Houghton, bacteriology and immunology.

Dr. Edward B. Glassman of the UNC School of Medicine is the first elected president of the newly

formed North Carolina Chapter of the Society of Neurosciences.

New appointments to assistant professor include: David W. Ange, Department of Radiology; William J. Arendshorst, Department of Physiology; Edward E. Ragoff, Department of Radiology; and Rick I. Suberman, Department of Radiology.

Promotions (professors) include: Arthur L. Finn, medicine; Mario C. Battigelli, medicine and School of Public Health; Robert A. Briggaman, dermatology; Floyd A. Fried, surgery; Joseph H. Perlmutter, physiology; and, Mary C. Singleton, physical therapy.

Promotions (associate professors) include: David R. Brown, anesthesiology; Timothy K. Gray, William Grossman and Don W. Powell, medicine; Faustino C. Guinto, Jr., radiology; and Edwin T. Preston, surgery.

Dr. James A. Bryan, II, professor of Medicine and Family Medicine at the UNC School of Medicine, for the third time, was named "Professor of the Year" by the 1974 senior class.

Dr. Frederic G. Dalldorf, professor of pathology, was named recipient of the 1974 Central Carolina Bank Excellence in Teaching Award at the UNC School of Medicine's Student-Faculty Day program April 27.

Other awards included the following: the second-year class gave the Medical Basic Science Teaching Award to Dr. James N. Weakley, assistant professor of physiology; Dr. Gordon Leigh Phillips, a resident in medicine, was voted recipient of the Henry C. Fordham Award by the fourth-year medical students; Dr. James Nello Martin, Jr., 1973 graduate of the UNC School of Medicine, was given the Outstanding Intern Award by the third-year students; and, Richard Nixon Duffy, III, received the William deB. MacNider Award, established by the second-year class of 1950.

Dr. James A. Bryan, II, professor of Medicine and family medicine, made his graduation address on three men who shaped the UNC School of Medicine—Drs. William MacNider, Richard Whitehead, and Isaac Manning. It was a new perspective for the 96 graduating students.

* * *

The following students and a faculty member of the UNC School of Nursing were honored May 12 at the School's special commencement: Celeste Ann Roberson of Fayetteville received the George Livas Award; Deborah Jane Carpenter of Gastonia, Alumni Award; Carol Lynn Zimmerman of Upper Montclair, N. J., Sigma Theta Tau Award; and, Betty Ann Taylor of Orlando, Fla., Sigma Theta Tau Writing Award. Instructor Bobbie Sue Frye was presented the Nursing Faculty Award.

State Senator Ralph H. Scott of Alamance County addressed the UNC School of Nursing graduating class on May 12. There were 110 bachelor of science degrees and 18 master's degrees awarded.

Promotions in the School of Nursing include: Vir-

Rondomycin

(methacycline HCl)

CONTRAINDICATIONS Hypersensitivity to any of the tetracyclines.

WARNINGS Tetracycline usage during tooth development (last half of pregnancy to early years) may cause permanent tooth discoloration (yellow-gray-brown), which is more common during long-term use but has occurred after repeated short-term courses. Enamel hypoplasia has also been reported. Tetracyclines should not be used in this age group unless other drugs are not likely to be effective or are contraindicated.

Usage in pregnancy. (See above **WARNINGS** about use during tooth development.) Animal studies indicate that tetracyclines cross the placenta and can be toxic to the developing fetus (often related to retardation of skeletal development). Embryotoxicity has also been noted in animals treated early in pregnancy.

Usage in newborns, infants, and children. (See above **WARNINGS** about use during tooth development.)

All tetracyclines form a stable calcium complex in any bone-forming tissue. A decrease in fetal bone growth rate observed in premature given oral tetracycline 25 mg/kg every 6 hours was reversible when drug was discontinued.

Tetracyclines are present in milk of lactating women taking tetracyclines.

To avoid excess systemic accumulation and liver toxicity in patients with impaired renal function, reduce usual total dosage and, if therapy is prolonged, consider serum level determinations of drug. The anti-anabolic action of tetracyclines may increase BUN. While not a problem in normal renal function, in patients with significantly impaired function, higher tetracycline serum levels may lead to azotemia, hyperphosphatemia, and acidosis.

Photosensitivity manifested by exaggerated sunburn reaction has occurred with tetracyclines. Patients apt to be exposed to direct sunlight or ultraviolet light should be so advised, and treatment should be discontinued at first evidence of skin erythema.

PRECAUTIONS If superinfection occurs due to overgrowth of nonsusceptible organisms including fungi, discontinue antibiotic and start appropriate therapy.

In venereal disease, when coexistent syphilis is suspected, perform darkfield examination before therapy, and serologically test for syphilis monthly for at least four months.

Tetracyclines have been shown to depress plasma prothrombin activity; patients on anticoagulant therapy may require downward adjustment of their anticoagulant dosage.

In long-term therapy, perform periodic organ system evaluations (including blood renal, hepatic).

Treat all Group A beta-hemolytic streptococcal infections for at least 10 days. Since bacteriostatic drugs may interfere with the bactericidal action of penicillin, avoid giving tetracycline with penicillin.

ADVERSE REACTIONS **Gastrointestinal** (oral and parenteral forms): anorexia, nausea, vomiting, diarrhea, glossitis, dysphagia, enterocolitis, inflammatory lesions (with local overgrowth) in the anogenital region.

Skin: maculopapular and erythematous rashes, exfoliative dermatitis (uncommon). Photosensitivity is discussed above. (See **WARNINGS**.)

Renal toxicity: rise in BUN, apparently dose related. (See **WARNINGS**.)

Hypersensitivity: urticaria, angioneurotic edema, anaphylaxis, anaphylactoid purpura, pericarditis, exacerbation of systemic lupus erythematosus.

Bulging fontanels: reported in young infants after full therapeutic dosage, have disappeared rapidly when drug was discontinued.

Blood: hemolytic anemia, thrombocytopenia, neutropenia, eosinophilia. Over prolonged periods, tetracyclines have been reported to produce brown-black crosshatched discoloration of thyroid glands; no abnormalities of thyroid function studies known to occur.

USUAL DOSAGE: Adults—600 mg daily, divided into two or four equally spaced doses. More severe infections: an initial dose of 300 mg followed by 150 mg every six hours or 300 mg every 12 hours. Gonorrhea: In uncomplicated gonorrhea, when penicillin is contraindicated, Rondomycin (methacycline HCl) may be used for treating both males and females in the following clinical dosage schedule: 900 mg initially, followed by 300 mg q.i.d. for a total of 5.4 grams.

For treatment of syphilis, when penicillin is contraindicated, a total of 18 to 24 grams of Rondomycin (methacycline HCl) in equally divided doses over a period of 10-15 days should be given. Close follow-up, including laboratory tests, is recommended.

Eaton Agent pneumonia: 900 mg daily for six days.

Children—3 to 6 mg/lb. day divided into two to four equally spaced doses.

Therapy should be continued for at least 24-48 hours after symptoms and fever have subsided.

Concomitant therapy: Antacids containing aluminum, calcium or magnesium impair absorption and are contraindicated. Food and some dairy products also interfere. Give at one hour before or two hours after meals. Pediatric oral dosage forms should not be given with milk formulas and should be given at least one hour prior to feeding.

In patients with renal impairment (see **WARNINGS**), total dosage should be decreased by reducing recommended individual doses or by extending time intervals between doses.

In streptococcal infections, a therapeutic dose should be given for at least 10 days.

SUPPLIED Rondomycin (methacycline HCl): 150 mg and 300 mg capsules, syrup containing 75 mg/5 cc methacycline HCl.

Before prescribing, consult package circular or latest PDR information. Rev 13

 WALLACE LABORATORIES
CRANBURY, NEW JERSEY 08512

ginia F. Gover, professor, and Joyce A. Semradek and Sylvia K. Hart, associate professor.

* * *

Dr. Charles C. Pulliam has been chosen one of eight scholars at UNC-Chapel Hill to receive a Spencer Foundation grant to study "The Pharmacist's Impact as a Health Educator for the Hypersensitive Patient." The eight UNC scholars will share a \$90,000 grant.

W. Whitaker Moose of Mt. Pleasant delivered the annual School of Pharmacy commencement address. This year bachelor of science degrees were awarded to 85 men and 43 women.

More than 200 persons attended a testimonial dinner May 13 honoring Dr. George P. Hager, Jr., who is resigning as dean of the UNC School of Pharmacy to return to teaching.

* * *

North Carolina physicians who invest a large part of their professional time in nursing homes met May 29 in Chapel Hill to take stock of their unique role. These physicians may become known as "medical directors" in the nursing homes to which they give concentrated attention as a result of a new federal regulation.

On an invitation from the United Methodist Church, Dr. James E. Allen has written a book, *The Early Years of Marriage*, for use in church-related discussion groups. Dr. Allen, an ordained minister, is a lecturer in the Department of Religion and an associate professor in the Department of Health Administration. He also serves as a senior research associate for the Carolina Population Center.

Dr. Philip C. Singer, associate professor in the UNC Department of Environmental Sciences and Engineering, has been named the first recipient of the Newton Underwood Award for Teaching Excellence.

John W. Hatch has been appointed associate professor, Department of Health Education. He is currently a research associate for the UNC Health Services Research Center.

Promotions include the following: Associate professor — Linda W. Little, environmental sciences and engineering; Ronald W. Helms, Richard H. Shachtman and Michael J. Symons, biostatistics; Assistant professor — Beatrice B. Mongeau, public health nursing.

Arthur C. Stern, professor in the Department of Environmental Sciences and Engineering at the UNC School of Public Health has been elected first vice president of the Air Pollution Control Association.

Drs. Michel Ibrahim and Dennis Gillings of the School of Public Health have been presented Founders Awards by the North Carolina Heart Association for their contribution and participation in the Association's programs.

* * *

Some of the South's most colorful spokesmen for the poor and hungry joined church, civic, educational and government officials at UNC-Chapel Hill re-

cently to work out detailed plans to feed the poor, the aged, and the hungry in eight southern states.

* * *

Dr. Craig T. Ramey, psychologist, and Dr. Albert M. Collier, pediatrician, of the Child Development Center have been awarded a Spencer Foundation grant to study "The Effects of Febrile Illnesses on Learning in Preschool and Elementary School Children." Drs. Ramey and Collier will share a \$90,000 grant with six other UNC-Chapel Hill Spencer Foundation Scholars.

* * *

Family planning directors from throughout North Carolina met in Chapel Hill June 12-14 for an evaluation workshop sponsored by the State Services Office of the Carolina Population Center of UNC-Chapel Hill.

* * *

The North Carolina Health Manpower Development Program at UNC-Chapel Hill has received a \$15,000 grant from the Z. Smith Reynolds Foundation, Inc., of Winston-Salem to support a clinical work-study summer health program this summer for 75 minority and disadvantaged students enrolled at the following schools: Pembroke State University, North Carolina Central University, Elizabeth City State University, Durham College, and UNC-Chapel Hill.

News Notes from the—

DUKE UNIVERSITY MEDICAL CENTER

Edwin C. Whitehead of Tarrytown, N. Y., has announced that he will establish a multi-million-dollar "purpose-oriented" biomedical research institute on the campus of and in association with the medical center.

Whitehead is chairman of the board of directors of Technicon Corporation of Tarrytown and owns the bulk of the stock of Technicon.

The research center will be known as the Whitehead Institute for Medical Research. It will be affiliated and associated with Duke Hospital and the School of Medicine, providing for a joint effort between the institute, the hospital, the medical school, and members of the staffs of each organization.

Initially, Whitehead will commit sufficient funds to provide an operating budget of approximately \$1 million for the institute's operations, and in the future capital funds consisting of Technicon stock will be made available for endowment of the institute.

Technicon was started as a one-room operation in 1939 by Whitehead and his father. Today the corporation has five major divisions, eight distribution centers in the United States and Canada, and has offices in 20 other countries.

Technicon manufactures scientific instruments

used primarily for automated chemical analysis of blood, blood serum, air and water (for pollution content) and various chemicals, pharmaceuticals, foods, and other products for quality control and production monitoring.

Whitehead emphasized that the institute will be "purpose-oriented" in its research efforts, explaining that "the major goals will be long in range and each will encompass the definitive solution of a major problem area in medicine."

The selection of Duke as the site for the institute came after an exhaustive search of more than a year by Whitehead and his associates for a university setting where his institute's work would tie in with existing biomedical research programs.

Whitehead said that he and his advisors, headed by Dr. James A. Shannon, special assistant to the president of Rockefeller University and former director of the National Institutes of Health, had visited and considered more than 10 leading universities in the country before selecting Duke.

The institute will be self-governing through a board of directors which will have a mutually interlocking relationship with the University Board of Trustees.

Overall guidance will be in the hands of a chief executive officer to be known as the director of the institute. The director is expected to be selected within the next few months.

Research programs of the institute's work will be determined on the advice of a scientific advisory

group made up of some of the world's most distinguished scientists.

* * *

Duke has received as a gift a private collection of rare books considered to be one of the finest private collections in the history of science and medicine.

The collection contains hundreds of first editions, and a number of the books date from just after the dawn of printing in the 15th century.

The donors are Samuel I. and Cecile M. Barchas of Sonoita, Ariz. They declined to disclose the exact appraised value of the collection, but it is in the millions of dollars.

Barchas was a prominent trial lawyer in Los Angeles in Beverly Hills before his retirement to Arizona in 1956.

"We investigated all of the leading institutions in the country that we thought had the scholarly purposes and capabilities of receiving a unique collection of this kind," Barchas said. "After six years, we determined that, because of its excellence, Duke was the ideal place for these books."

Under the terms of an agreement signed by the Barchases and President Terry Sanford, Duke will supplement the Barchas Collection by acquisitions totaling \$100,000 annually for at least ten years.

The books, which total approximately 3,250 volumes, will be known as the Samuel I. and Cecile M. Barchas Collection. They will be housed in

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CATHERINE T. RAY, M.D.

WEIR M. TUCKER, M.D.

GEORGE S. FULTZ, JR., M.D.

GRAENUM R. SCHIFF, M.D.

ne Barchas Center for the History of Science, located in the medical library section of the Seeley G. Mudd Building, the library and communications center which will be completed in the fall of 1975.

The Barchas Collection will be located adjacent to the Josiah C. Trent Collection, one of the country's major collections of books on the history of medicine.

Duke also has agreed to begin a program of publishing scholarly books and monographs in the history of science and medicine growing out of research in the Barchas Center, and to translate into English and publish classics in the field.

The Barchas Center will have a director appointed from the Duke faculty and an editor-in-chief of the collection. A six-member committee, on which the Barchas will serve, will manage and guide the collection, including future acquisitions.

* * *

Dr. Roy T. Parker is the new president-elect of the American College of Obstetricians and Gynecologists (ACOG) and will be president during the organization's silver anniversary year, 1975-1976.

Parker's predecessor as chairman of the Department of Obstetrics and Gynecology, Dr. F. Bayard Carter, is a past president of ACOG, as was the late Dr. Robert A. Ross. Another past president is the retired department chairman at Bowman Gray, Dr. Frank R. Lock.

"This makes our district (District IV) the only district in the ACOG, and North Carolina the only state, that will have produced four national presidents," Parker said. The ACOG has 16,000 members in the United States and Canada.

* * *

Russell James Kilpatrick, a rising junior in the School of Medicine, from Asheboro, N. C., has been elected as the 1974 winner of the Wilburt C. Davison Travel Scholarship, an award presented annually to an outstanding medical student.

The award, amounting to \$500, will be used by Kilpatrick to help offset the cost of two months in Johannesburg, South Africa, at the University of Witwatersrand where he plans to study advanced general and thoracic surgery. The student said he also intends to visit medical missionaries in Zaire, formerly the Republic of the Congo.

Kilpatrick is a 1972 graduate of the University of North Carolina at Chapel Hill and has a bachelor of arts degree in economics. While at UNC, he was a Morehead scholar.

* * *

Dr. James J. Morris, Jr., associate professor of medicine and director of the Myocardial Infarction Research Unit, was installed as president of the North Carolina Heart Association during the 25th annual meeting of the organization in Winston-Salem.

News Notes from the—

BOWMAN GRAY SCHOOL OF MEDICINE WAKE FOREST UNIVERSITY

Dr. I. Meschan, professor and chairman of the Department of Radiology at Bowman Gray, and Dr. James F. Martin, professor of radiology, are co-authors of a new book on the diagnosis of head and neck disorders. Collaborating with them on the book was Dr. Lee F. Rogers, associate professor of radiology at the University of Texas Medical School in Houston.

The *Head and Neck Disorders Syllabus* is included in a series of 14 books being published by the American College of Radiology as part of its program on professional self-evaluation and continuing education.

* * *

Dr. John R. Ausband, professor of otolaryngology, has authored a new book called *Ear, Nose and Throat Disorders*. The book is presented as a guide for the practicing physician caring for patients with problems of the ear, nose and throat. It also includes sections on neck masses, the salivary glands and the facial nerve.

* * *

Dr. Richard C. Proctor, professor and chairman of the Department of Psychiatry, has written an article entitled "Winners Walk Alone" which appears in the *1974 PGA Book of Golf*. The article deals with the psychological differences between winners and losers.

* * *

Dr. Jimmy L. Simon, professor and chairman of the Department of Pediatrics, has received special recognition for teaching excellence from the 1974 graduating class of the University of Texas Medical Branch at Galveston. Dr. Simon was deputy chairman of pediatrics at Galveston prior to his appointment to the Bowman Gray faculty in March.

He was presented the James W. Powers Award, which is the highest honor the students at the University of Texas Medical Branch can bestow upon a faculty member. This is the second time Dr. Simon has won the Powers Award.

* * *

Dr. Robert N. Headley, associate professor of medicine, was elected as a North Carolina Heart Association member on the American Heart Association Board of Directors at the May 30 N.C.H.A. meeting in Winston-Salem. He also was awarded the Silver Distinguished Service Medallion for outstanding leadership.

* * *

George Lynch, professor and director of the Department of Audiovisual Resources, has been reapp-

pointed as consultant to the Committee on Medical Education of the North Carolina Medical Society.

* * *

Dr. Joseph E. Whitley, professor of radiology, recently became the first member of the Association of University Radiologists to be elected to membership on the American College of Radiology Council.

* * *

Dr. Hal T. Wilson, associate professor in the Division of Allied Health, has been elected secretary of the Executive Committee of the Piedmont Medical Foundation.

* * *

Dr. Paul C. Bucy, an internationally prominent neurosurgeon, has been appointed clinical professor of neurology and neurosurgery.

He is professor emeritus and former director of neurosurgery at Northwestern University Medical School. He now lives in Tryon.

* * *

Dr. James C. Leist has been appointed an assistant to the vice president for medical affairs. His primary responsibilities will be in the development of an Area Health Education Center (AHEC) program to serve a 16-county area in northwest North Carolina.

He also will hold a faculty appointment as instructor in community medicine.

For the past two years he has been director of health manpower planning for the Forsyth Health Planning Council in Winston-Salem.

AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS

Dr. Roy T. Parker of Durham, North Carolina, was named president-elect of the American College of Obstetricians and Gynecologists (ACOG) at the College's recent annual meeting in Las Vegas.

Dr. Parker, who is chairman of the Department of Obstetrics and Gynecology at Duke University Medical Center, will head the 15,875 member obstetrics-gynecology specialty organization in 1975-1976.

A 1941 graduate of the University of North Carolina, he received his M.D. degree from the Medical College of Virginia in 1944. He was appointed assistant professor in the Department of Obstetrics and Gynecology at Duke in 1955, professor in 1963, chairman in 1964, and was named F. Bayard Carter Professor of Obstetrics and Gynecology in 1970.

NORTH CAROLINA HEART ASSOCIATION

The North Carolina Heart Association has set a deadline of October 1, 1974, for receiving applications for research grants-in-aid up to \$2,500, except in unusual circumstances when it will consider applications for larger amounts from investigators within the state working in the cardiovascular field. Grants-in-aid are awarded by the Heart Association and its

chapters to scientists to serve as pilot projects and as a method of encouraging postdoctoral scientists toward a research career. Preference in funding will be given to junior investigators.

Applications for the grants may be forwarded to William E. Lassiter, M.D., Chairman, Research Review Subcommittee, North Carolina Heart Association, P. O. Box 2408, Chapel Hill, North Carolina 27514.

The grants-in-aid are one phase of the Heart Association's research program which is supported by public contributions to the annual Heart Fund campaign.

The North Carolina program is separate from that of the American Heart Association, which annually makes numerous research grants to scientists within the state. Those interested in inquiring about the national program should write to the American Heart Association, 44 East 23rd Street, New York, New York 10010.

POLYCYTHEMIA VERA STUDY GROUP— MYELOPROLIFERATIVE DISORDERS: A NEW INTERNATIONAL STUDY

The Polycythemia Vera Study Group (PVSG) was organized seven years ago to better define the natural history of the disease, the optimal therapy and the influence of the various therapeutic modalities on the course of the disease, particularly in the development of myeloid metaplasia, myelofibrosis and acute leukemia. Four-hundred and ten patients with polycythemia vera have already been entered into this randomized prospective study, and these cases are being followed.

The PVSG has recently instituted a major new protocol to study other myeloproliferative syndromes exclusive of granulocytic leukemias. Previously untreated patients diagnosed as having agnogenic myeloid metaplasia, myelofibrosis or sclerosis, primary thrombocytosis, or unclassifiable myeloproliferative variants will be enrolled for study. The twofold purpose of including other myeloproliferative disorders in the study is to learn as much as possible about the pathophysiology of these disorders and to perform randomized therapeutic trials to determine the most effective therapy.

Each patient will receive extensive diagnostic testing aimed at quantitating blood and bone marrow function and structure, relevant chemistries, cytogenetics, levels of growth stimulators such as erythropoietin and colony stimulating activity, and feline rokinetics. To determine common patterns of disease progression and to identify prognostic factors, key observations will be repeated at regular intervals. Such comprehensive testing requires the combined efforts of many hematology centers. The therapeutic trials are designed to answer the following questions: (1) how frequently do androgens improve anemia? (2) is there a difference between the remission rate of low dose androgens and high dose androgens, and

are oral androgens as useful as parenteral androgens?; (3) how does splenectomy compare to chemotherapy in treatment of patients having severe hemolytic manifestations and painfully enlarged spleens?; (4) what are the relative merits of P^{32} in comparison to chemotherapy (1-phenylalanine mustard) in treatment of primary thrombocytosis?; (5) how often do patients with MPS have coexisting iron or folate deficiency, and do they benefit from replacement?

There are 43 cooperating institutions in the United States, France, Sweden and Israel. We welcome in-

quiries regarding entry and follow-up of potential study patients. Patients undergoing investigative studies may be admitted to the Clinical Research Unit at the participating institutions. Further information can be provided by PVSG or by the individual investigators at the following addresses: John Laszlo, M.D., Box 3096, Duke University Medical Center, Durham, North Carolina 27710, (919-684-2512); Charles L. Spurr, M.D., Division of Hematology, Bowman Gray School of Medicine, Winston-Salem, North Carolina 27103 (919-727-4354).

Month in Washington

The humdrum hearings on national health insurance (NHI) before the House Ways and Means Committee got something of a lift when the long-absent chairman, Wilbur D. Mills (D-Ark.), unexpectedly showed up one Friday in mid-June and announced that whatever bill his committee approves undoubtedly would not look like any single bill presently under consideration.

This pronouncement from the august chairman immediately gave rise to the belief that closed door talks may be going on among committee members in an effort to hack out a compromise bill that could secure congressional enactment this year.

But the startling lack of interest in the House Ways and Means Committee hearings—only two or three members attending each hearing and chairman Mills showing up for only the second time in months—and the indefinite postponement of Senate Finance Committee hearings would seem to say the Congress is not “busting its britches” to pass an NHI bill this year.

Mills said his own plan (Mills-Kennedy) “doesn’t do everything I would like it to do.” He added, however, that he believes the method of reimbursing physicians under Mills-Kennedy is better than Medicare’s method. Mills believes it would eliminate the apparent discrimination between the city physician and the rural physician.

His primary concern is that medical services for the poor be at least as good as that received by those people in other income groups. Referring to the compromise with Kennedy, he said, “We were trying to lay before the public a program we thought had a chance to pass.” He said he wanted to avoid a bill that “would provide nothing more than catastrophic coverage,” which would cover only five percent of the need. Mills said that the compromise is subject to further compromise. “Catastrophic is

the roof, and we need the floor and walls along with the roof,” he said.

Mills stated that his intent with the Mills-Kennedy compromise NHI bill was not to exceed the cost of the Administration’s “CHIP” plan and to come up with a different method of financing. He said the bill was introduced to present an alternative to the Administration plan for discussion and comment.

The following selected sample bits of testimony are from the many medical-health care oriented organizations who have trooped to Washington to have their say about NHI:

(1) The American Public Health Association urged more consumer policy input than provided in any of the major NHI bills before the committee and more preventive services benefits. APHA President C. Arden Miller, M.D., said the major measures, for the most part, provide insufficient benefits and controls.

(2) The American Association of Medical Clinics supported maintenance of the free enterprise system of health care, and said that funding should be from mandated employer plans and general tax funds for the poor and medically indigent.

(3) The Colorado Health and Environment Council witness discussed the Colorado Community-Cooperative-Decentralized plan which emphasizes preventive medicine and home health care. The importance of the physician’s office as a basic health care facility was stressed.

(4) The National Association of Social Workers favored the Kennedy-Griffiths Health Security Act provisions.

(5) The American Academy of Family Physicians told the House Ways and Means Committee that any NHI bill must provide that family physicians receive the same fee as other specialists when providing the same service. Family physicians should not be

treated as "second class members of the health care delivery team," said James Price, M.D., Academy president.

He told the committee that wealthier people should pay a greater portion of the cost for catastrophic coverage as provided in the American Medical Association's Mediredit plan.

"We are skeptical as to just how all-encompassing a program can be effectively administered by the federal government and would strongly urge that, insofar as possible, continued reliance be placed on the expertise which has been developed by the private insurance industry," he said.

Dr. Price opposed a provision of the Mills-Kennedy bill (Medicare for all) regarding payment for services by specialists, saying that the determination of which physicians should not be providing specific services should be left to their peers rather than to the Social Security Administration.

(6) Another witness, Donald Schiff, M.D., of the American Academy of Pediatrics, said, "We must build upon the strengths of our present medical care system, taking special pains to retain the currently

productive programs such as Crippled Children's, Maternal and Child Health, and Children and Youth."

Dr. Schiff said that preventive health services should encompass the entire pediatric age scale to 21 years. Deductibles and coinsurance should not be used for preventive health care for children or pregnant women, he asserted. Comprehensive child health care should be a spelled-out benefit, and increased funding of psychological services is necessary, according to the physician. He urged the creation of a cabinet post, Secretary of Health.

(7) Ned Parish, president of the National Association of Blue Shield Plans, said that the concept of a totally tax-supported and government-administered national health program is "a solution for a problem which no longer exists."

"We have built in America a private system which extends to the vast majority of the population and serves most of them quite well," he said.

Declaring that the public does not support radical restructuring of the health system or its financing, Parish said federal action is clearly necessary that



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would strengthen private coverage and, at the same time, eliminate problems that "can never be resolved without the active participation of government."

He called for: federal financing of coverage for the poor and medically indigent; catastrophic coverage not federally-financed, tied to a program of basic benefits; regulation of carriers, with respect to covered benefits and solvency; minimum standards for coverage; and, free choice and maximum participation by the private sector.

(8) In other testimony, the U.S. Chamber of Commerce urged approval of its own mandated-coverage NHI plan as "realistic, reasonable and affordable." The Mills-Kennedy plan would lead to "federal domination of the health program" and impose excessive new payroll taxes, the Chamber said. The Administration's CHIP plan would significantly increase costs to small and medium-sized businesses, and the AMA's Mediredit plan is not comprehensive enough, according to the Chamber.

(9) Pharmaceutical Manufacturers Association President C. Joseph Stetler said the Mills-Kennedy bill provision for a restrictive national formulary for out-patient drugs would distort prescribing decisions. The PMA is most concerned with the proposed price controls on drugs, Stetler testified. This would force a diversion of sales from research-based firms to the nonresearching sector, he said.

(10) The National Protestant-Catholic Hospital Association said the Mills-Kennedy bill does not adequately ensure that hospitals will be reimbursed for their costs and could force nonprofit hospitals "into a hand-to-mouth existence." Voluntary donations would cease, the Association warned.

(11) The Consumer Federation of America favored the labor-backed Health Security bill, and argued that sole reliance on payroll tax, as in Mills-Kennedy, is regressive. The Federation indicated it would prefer a program financed solely out of general revenues.

(12) The National Cancer Foundation contended that all bills fall short of providing adequate catastrophic coverage.

(13) The National Association for Mental Health held that legislation should emphasize outpatient services and stimulate Comprehensive Community Mental Health Centers.

(14) The National Kidney Foundation said, "We have major trepidation about the ability of existing administrative machinery to manage an NHI program of far greater dimensions and scope than the end stage renal disease program."

* * *

P. O'B. Montgomery, M.D., of Dallas, has been nominated by the President to the Board of Regents of the new Uniformed Services University of the Health Sciences.

Dr. Montgomery, a professor of pathology at the University of Texas Southwestern Medical School, was named to serve the remainder of the four-year

term of Anthony R. Curreri, M.D., recently appointed president of the new school. The nomination goes to the Senate for approval.

Other members of the board of the new school include Malcolm Todd, M.D., president of the AMA; Charles E. Odegaard, M.D., president of the University of Washington; Joseph D. Matarazzo, M.D., chairman of medical psychology, University of Oregon Medical School; Durward G. Hall, M.D., a recently retired Congressman from Missouri; Alfred A. Marquez, M.D., of San Francisco, and Lt. Gen. Leonard D. Heaton, MC, USA (Ret.).

* * *

Working on a sweeping tax reform bill, the House Ways and Means Committee tentatively has decided to change the tax laws affecting medical deductions and business expenses that would affect consumers and physicians.

Apparently with an eye on the possibility of a national health insurance program being enacted, the Committee voted to remove the present deduction for one-half the amount an individual pays for his health insurance premium (up to \$150), and to increase the present three percent of income floor applicable to medical expenses to five percent. The one percent of income test for drug costs would be abandoned, with the drug expenses coming under the five percent medical expenses category. Only prescription drugs would be covered.

In addition, the Committee decided to do away generally with the sick pay exclusion under which a tax break is provided employees who are paid while sick beyond a certain length of time.

In the business field, the Committee closed the door on business expenses resulting from attending conventions overseas (excluding Puerto Rico, Hawaii, and American possessions) unless there is an overriding reason for holding the meeting abroad. All cruise ship business expenses would not be acceptable, if the Committee's decision should be enacted by Congress.

* * *

Florida's experience is that the average start-up time for a full service Health Maintenance Organization (HMO) is three to five years. Tampa physician-legislator Richard S. Hodes, M.D., has told the House Ways and Means Committee.

Testifying at the Committee's national health insurance hearings, Dr. Hodes headed a delegation of the National Legislative Conference, an organization of state legislators.

Dr. Hodes outlined Florida's recent activities in health services, noting that unless federal support is continued for such programs as Hill-Burton, Comprehensive Health Planning and Regional Medical Programs, a state's health program might be further snarled by adding national health insurance.

Dr. Hodes is chairman of the Florida House of Representatives Committee on Health and Rehabili-

tative Services, and heads the Human Resources Task Force of the National Legislative Conference's Intergovernmental Relations Committee.

Florida has had an HMO licensing act for more than two years, he noted, but thus far, only five are licensed.

Careful licensing to ensure both the quality care and financial soundness has protected the patient, "but the experience has taught us a hard lesson," he said.

"This lesson is that the average start-up time for a full service HMO is from three to five years, and that the popular conception of HMOs as a panacea for our ills is unfounded. In fact, HMOs have a somewhat limited utility since the institution is totally dependent on resources within the community," said Dr. Hodes.

Rural HMOs will require more time and planning before they can become one of the remedies for rural health needs, he added.

Book Reviews

Treatment of Cardiac Emergencies. By Emanuel Goldberger, M.D. 355 pages. Price, \$14.00. St. Louis, Missouri: C. V. Mosby Company, 1974.

This 346-page manual on the diagnosis and treatment of cardiac emergencies represents a distillation of the larger, more comprehensive textbooks of cardiology. Dr. Goldberger has developed within this monograph an orderly breakdown of the major emergencies with pertinent topics which are well indexed and referenced. The book is appropriately divided into subtopics so that a synopsis can be achieved with relative ease and dispatch.

This reviewer finds the content scientifically accurate and current. The sections on temporary and permanent pacing are particularly informative and well written. The electrocardiographic figures are abundant and accurate.

Dr. Myron Wheat's chapter on aneurysms reiterates a position which he has espoused on numerous occasions in the medical literature.

In summary, this reviewer would judge the manual to be basic, yet adequate for the needs of the generalist and internist. It is scientifically accurate, well organized, and presented in an orderly format. This handbook should find good use in the offices of generalists, internists, and in the emergency departments, ICU's, and CCU's of general hospitals. As the *Merek Manual*, this manual might also become well utilized by house officers in training.

ROBERT N. HEADLEY, M.D.

A Surgeon's Odyssey. By Loyal Davis, M.D. 336 pages. Price, \$8.95. New York: Doubleday & Co., 1973.

Loyal Davis stands as one of the strong influences in American medicine of the past 20 years. A man of brilliance, energy and integrity, he is outspoken sometimes to his own detriment, but is rarely

compromising in matters he considers of high principle.

In his *A Surgeon's Odyssey*, he has written an autobiography, liberally interspersed with his own thoughts and opinions. In several instances, as in his struggle on behalf of the American College of Surgeons to stop fee-splitting among surgeons, he has offered an explanation for his strong opinions.

As a neurosurgeon and chairman of a department of surgery at Northwestern University, Davis was in a position to influence the direction to be taken by medical educators and to influence the lives of many students who, by good fortune, worked and learned under him.

He was in the top echelon of almost all surgical organizations in this country, including the U.S. Army Medical Corps in World War II, the American College of Surgeons and the American Surgical Association. His longstanding position of prominence permitted him to comment frankly concerning his acquaintance with the surgical leaders of the past two decades. These observations are sometimes more critical than one usually sees in print, but they come from a conscience motivated to correct all wrongs if possible and to "tell it like it is."

His three heroic figures were: his father, a skilled engineer with the Burlington Railroad; Allen Kanavel, one of the nation's most skilled surgeons; and Harvey Cushing, under whom Loyal Davis spent a year of his training.

To most surgeons and neurosurgeons (the group who will profit most by reading this book), his intimate glances and frank comments regarding Kanavel and Cushing will be of greatest interest.

Chapter six of the book is almost exclusively a description of Loyal Davis' experience with Dr. Cushing and is the strongest portion of the book. It is the most well-written and well-organized section, since it deals with one period of time; it does not suffer the fate

of much of the rest which skips from one subject to another, from one person to another, and, in fact, almost without notice, from one time to another.

There are observations about Dr. Cushing which are not recorded elsewhere, and some of the recorded impressions arising between two strong men, Cushing and Davis, are worthy of reflection. There is one unique reference to a small joke Dr. Cushing told on himself. In this instance Dr. Cushing told the following story to his assembled staff:

"You all know Gus, my chauffeur. I came out of the house this morning to find the lawn strewn with leaves, the front porch filthy dirty, the car needed washing, and Gus was standing there holding the door of the automobile open, trying his best to appear like a footman. The whole scene irritated me. I told him he should be ashamed of the way he had neglected to keep the place and the car clean and orderly." He paused and grinned broadly. Then, "Gus listened with a patient look on his face. As he closed the door, he peered in at me and said, 'You forgot to wipe the egg off your chin, Dr. Cushing.'"

Loyal Davis' recording of the development of Northwestern University and its affiliated hospitals, his observations of the beginning of the American College of Surgeons and *Surgery, Gynecology, and Obstetrics*, of which he has been editor, and his poignant opinions of how one should conduct himself

in a surgical practice are strong points in this interesting book.

I recommend the book to many types of readers, but particularly to those trained and in training in surgery and neurosurgery.

E BEN ALEXANDER, JR., M.D.

Parents Guide to Allergy in Children. By Claude A. Frazier, M.D. 338 pages. Price, \$7.95. Garden City, N. Y.: Doubleday & Company, Inc., 1973.

In his preface, Dr. Frazier states that his intention was to make the complex problems of allergy comprehensible to the nonmedical reader. This he has accomplished in a reassuring way. Since allergy is "in" these days, it is important that all who are allergic understand the causes, the symptoms, the treatment, and the prognosis of their disease. From the beginning of the book, with Dr. Frazier's explanation of allergy as overprotection by the body, to the last statement of encouragement, there are 322 pages of good advice that destroys myths, undermines quackery and reveals the "mysteries" of allergy. All symptoms, from the most minor sniffle to the worst wheezing, are explained. I do not mean that Dr. Frazier has oversimplified; I mean that he has

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Sept 30 &
Oct 1, 1974

SEPT. 30, 1974

PROGRAM

Sept. 30 **MONDAY**

7:30 a.m. **REGISTRATION**
Read House

9:00 a.m. William H. Masters, M.D.
Virginia E. Johnson, St. Louis,
Mo., "SEX AND SEXUALITY"

10:00 a.m. **COFFEE BREAK**
Exhibit Visitation

10:30 a.m. Louis C. Lundstrom, General
Motors Corp., Warren, Mich.,
"THE STATUS OF AUTO
SAFETY" (GM ESV exhibit)

11:00 a.m. Joseph D. Godfrey, M.D.,
Buffalo, N.Y., "WHAT'S NEW
IN SPORTS MEDICINE?"

1:00 p.m. **LUNCHEON**
Continental Room

SPEAKER
Joseph D. Godfrey, M.D.
Team Physician, Buffalo Bills,
"CONTACT"

2:00 p.m.
to
4:00 p.m. **SYMPOSIUM**

"SEXUAL DYSFUNCTION"

William H. Masters, M.D.
and
Virginia E. Johnson

Reproductive Biology Research
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St. Louis, Mo.

(Symposium open to physicians,
physician's wives and RN's)



OCT. 1, 1974

PROGRAM

Oct. 1 **TUESDAY**

8:00 a.m. **REGISTRATION**
Read House

9:00 a.m. Wm. E. Thornton, M.D.,
NASA Houston, Tex.,
"WHAT'S NEW—SKYWARD?"

9:30 a.m. C. A. Harvey, M.D., Naval
Submarine Med. Res. Lab.,
Groton, Conn. **PACKAGED
ENVIRONMENTS—MAN'S
PROGRESS IN SUB-AQUATIC
SURVIVAL**

10:00 a.m. **COFFEE BREAK**
Exhibit Visitation

10:30 a.m. Peter C. Gazes, M.D.,
Charleston, S.C., "WHAT'S
NEW IN MEDICAL OFFICE
EMERGENCIES?"

11:00 a.m. E. C. Wong, Master
Acupuncturist, Denver, Colo.
"ACUPUNCTURE AS AN ADJUNCT"

11:30 a.m. Arthur Taub, M.D., Ph.D.,
New Haven, Conn.
"ACUPUNCTURE—AN
HISTORICAL ANALYSIS
AND PHYSIOLOGICAL
CRITIQUE"

1:00 p.m. **LUNCHEON**
Continental Room

SPEAKER
W. J. Lewis, M.D., Chairman,
AMPAC Board, Dayton, Ohio,
"POLITICAL ACTION—AN
EFFECTIVE LONG-RANGE
PLAN"

2:00 p.m.
to
4:00 p.m. **SYMPOSIUM**

"NEW MEDICAL HORIZONS IN
SPACE AND UNDER THE SEA"

Wm. E. Thornton, M.D.
NASA Houston Texas

C. A. Harvey, M.D.
Naval Submarine Medical Research
Laboratory, Groton, Connecticut

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done as he intended — he has made allergy understandable.

The only statement of Dr. Frazier's with which I can disagree is that insect desensitization injections should be postponed for four or five days after a child has been stung. Any immunity that hyposensitization therapy has given the child is essentially gone after that sting or bite, and therefore he needs his immunity started again immediately. Also, the continuation of desensitization can relieve his symptoms. We have completely relieved all symptoms of insect stings within a few hours by using the titration method. These remarks, however, represent only a personal disagreement, and a minor one.

Here, finally, is a publication that you, the allergist,

or pediatrician can recommend to distraught parents of moderately to severely allergic children. By reading it, parents will find answers to all those questions that they have asked when their physicians have often been too busy to answer fully. (Whether it should be recommended to parents of a child with mild allergies depends on the emotional maturity of the parent—they should be able to distinguish between their child's mild allergic problems and the very serious problems covered in the book.) Even the medical student or physician wishing to brush up on the symptomatology and management of allergies should find this book enlightening.

WALTER A. WARD, M.D.

In Memoriam

Nathan Carl Wolfe, Sr., M.D.

The New Hanover-Brunswick-Pender Medical Society expresses with deep regret the passing of Nathan Carl Wolfe, Sr., M.D., of Burgaw, North Carolina.

Dr. Wolfe's dedication to his profession, loyalty to his fellow physicians, and interest in people, which enhance his contribution in the life of residents of Pender County and the entire area, are a great tribute and challenge for all to emulate.

By his knowledge and his deeds, he won the respect and admiration of all with whom he came into contact, and these memories will live on with all of those who knew him and loved him.

Dr. Wolfe's quiet strength, sincerity and contributions to his profession combined in him a friend, a dedicated family man and distinguished physician.

The Tri-County Medical Society, on behalf of medical personnel, gratefully records its appreciation to Dr. Wolfe and adopts the following resolution:

BE IT RESOLVED, that the New Hanover-Brunswick-Pender County Medical Society extend the tribute in honor of Dr. Nathan Carl Wolfe, Sr., and that his services, his medical code of ethics, and feelings for his fellow man are personal attributes that distinguished him above most and endeared him to all, making it truly an honor in knowing him. He served in the capacities of all medical staff positions: Pender Memorial Hospital, the Pender County Health physician, and practicing physician, as a most treasured friend whom it was a special privilege for all to know.

BE IT FURTHER RESOLVED, that a copy of this resolution which shared the passing of a truly great person, whose deeds and memories live on with us, be furnished to the State Medical Journal, the newspapers and members of Dr. Wolfe's family.

NEW HANOVER-BRUNSWICK-PENDER COUNTY
MEDICAL SOCIETY

NORTH CAROLINA

Medical Journal

IN THIS ISSUE: Emergency Medical Services in North Carolina: I. A Proposal for the Organization of a Statewide Emergency Services System in North Carolina, Frank Cordle, M.P.H., Ph.D.; Drug Deaths in North Carolina: A Brief Survey of Deaths Attributed to Drugs in North Carolina, 1973, Arthur J. McBay, Ph.D., and Page Hudson, M.D.; To Commit or Not to Commit, A Continuing Dilemma: Some Guidelines, David Raft, M.D., David S. Werman, M.D., and Roger F. Spencer, M.D.



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Emergency Medical Services in North Carolina:

I. A Proposal for the Organization of a Statewide Emergency Services System in North Carolina

Frank Cordle, M.P.H., Ph.D.

DURING the past few years Emergency Medical Services (EMS) have received considerable national attention. There is evidence that a high percentage of emergencies, if treated promptly and properly, could result in a substantial saving in loss of life, disability, cost of medical care, long term use of medical facilities and loss of income during periods of impairment.

The magnitude of the problem of accidents and emergencies can be seen in data from the National Safety Council. In 1969 there were 100,000 disabling injuries from all types of accidents¹ with wage losses, medical expenses and administrative costs, resulting from trauma, totaling approximately \$13,000,000,000. The estimated cost of this pandemic of accidents is \$20 billion annually.^{2, 3}

The National Safety Council estimates that 105,000 civilian accidental deaths occur annually and approximately 47,000 are caused by vehicle injuries.⁴ The one-millionth traffic fatality occurred in 1951, and the present rate continues, the

two-millionth victim will die by 1976.⁵ Accidents are currently the third most common cause of death in the United States; the rate is slightly less than that of deaths from cardiovascular disease and cancer.⁶ Trauma is our leading cause of death in people under 40 years of age. More than fifteen million significant injuries of children under 14 years of age are occurring; of these injuries, more than 16,000 are fatal.⁵

The National Health Survey estimates that more than two million victims of accidental injury were hospitalized in 1965; they occupied 65,000 hospital beds for 22 million bed-days and they received the services of 88,000 hospital personnel.³ From the total number of disabling injuries, approximately 400,000 of these result in some degree of permanent impairment.

One of the major problems today in the provision of emergency care, in both the lay and professional areas of responsibility for such care, is the broad gap between knowledge and its application. In the military, excellence of initial aid, efficiency of transportation, adequate care during transportation, and energetic treatment of casualties are the major factors in the progressive decrease in death rates of battle casualties. Most, if not all, of these skills used

successfully by the military in the treatment of emergencies must be developed in the civilian population if an EMS is to operate in the way it can and should.

COMMUNICATIONS

A successful EMS involves many activities, including detection of the accident or emergency, notification of a proper EMS agency, dispatch of the proper equipment and personnel to the scene, adequate treatment at the scene and en route to the proper EMS facility, and proper emergency care and follow-up at the EMS facility.

A successful EMS involves many people, including the victim or victims, the people who detect the accident or emergency and notify an agency, operators and attendants of emergency vehicles, police and fire department personnel, physicians, nurses and other hospital personnel. Obviously, it is a complex system.

The first post-incident act after the detection of a medical emergency always involves communications in some form. Emergency medical incidents are detected by people whose ability to respond to such incidents depends upon their ability to recognize medical emergencies and on their knowledge about EMS. One of the weakest

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links in the chain of an EMS communications system may be the timing and handling of the notification to the appropriate EMS facility.⁷

Within a community or region, whether the emergency vehicle service is a private enterprise or a governmentally operated system, each ambulance system has traditionally developed its own operating procedures and definition of purpose, without much concern for other similar agencies. In many instances these systems are so parochial in their viewpoint that they may not work together. They fear loss of authority, prestige and funding. These private companies and governmental agencies have developed a myriad of communication systems for their own benefit. Few of them have made a real effort to provide the average citizen with full and quick access to their services.

In the event of an emergency in a rural community, or on a rural highway, often it is necessary that a person notify the local sheriff's department or the highway patrol, who then must contact the closest emergency service agency or unit. All of these activities take time, for they require retransmission of the notification message to the emergency service unit. Distortion and inaccuracy are common.

An ideal arrangement would be an EMS communication center that would receive all notification messages within its region of operation; dispatch the appropriate equipment and personnel to the scene; provide consultation for management and care of the victim to the emergency vehicle personnel en route to the EMS facility; and equally important, educate the public in the use of such an EMS communication system. In addition, it would be necessary to provide adequate information to people traveling through the area who are unfamiliar with the system.

Ideally, the coordinating system for communications should be located in a major EMS facility (which will be defined later) in the region with sub-systems at other levels of the EMS system in order to form an emergency communications network that is appropriate to

the needs and capabilities of the region. In general, the network should include interhospital links; direct hospital to emergency vehicle ties; and the central or coordinating center which has radio communications with all regional hospitals, emergency vehicle services and other public services. The capability for telemetry of physiological data between mobile units and designated EMS facilities, e.g., those having coronary care units, should also be provided.

Competent personnel are essential to any effective communication system. EMS hospitals must ensure that the personnel who operate the equipment are adequately trained, not only to operate the communications equipment, but, in the case of emergency medical services vehicle attendants, they must achieve a level of expertise that enables them to effectively use their vehicle communications and other equipment to deliver lifesaving care.

EMERGENCY MEDICAL SERVICE VEHICLE PERSONNEL

The increase in public and legislative demands for vast improvements in the EMS system should result in a critical evaluation of the role and training of those people who, in most accident cases, are responsible for the initial care given at the scene, as well as the care rendered en route to an EMS facility,⁸ namely, the individuals who man the EMS vehicles. In 1967, standards were published by the United States Department of Transportation concerning the requirements for such personnel. Under Standard II, the first eight minimal requirements were addressed to the need for the establishment of training, licensing and related requirements for ambulance and rescue workers. In 1968, the National Academy of Sciences and the National Research Council analyzed the regulations then current regarding ambulance services and training throughout the nation.⁹

One conclusion reached by the academy was that the courses of instruction lacked uniformity. The academy found that 70 different

programs, ranging in length from three hours to three and one-half days, used 20 different textbooks.

A second conclusion was that there was no generally accepted standard of proficiency. Only 1 states required training of emergency vehicle personnel, and only eight of these specified course content. Deficiencies noted by the academy included a lack of coverage in the following areas: (1) operation of medical equipment such as resuscitators and cardiac message equipment; (2) obstetrics; (3) communications; (4) extraction of victims from vehicles; (5) handling of multiple trauma situations; and (6) techniques for holding a patient in stable condition.

As a result of these findings, the Department of Transportation through a consulting firm, developed a basic course for Emergency Medical Technician I. The course was designed to be completed in 60 to 80 hours and would consist of two to three lessons given by various instructors. After reviewing a large selection of training manuals, the consulting group selected a textbook developed by the American Academy of Orthopedic Surgeons, *Emergency Care and Transportation of the Sick and Injured*. The training unit consists of 25 lesson units and an additional unit for clinical experience to be provided in a hospital.

Pilot programs conducted in several states have clearly demonstrated the value of training beyond the basic level.¹⁰ Such programs provide career opportunities for the emergency medical technicians who have a high level of ability, intent and motivation. The EMS-II course requires an understanding of why certain drugs and treatment are prescribed. It requires approximately 480 hours of classroom lectures and practice and an additional 500 hours of clinical practice and observation.

As in the case with other educational programs in which hospitals participate, course credits at community colleges should be sought for those people who successfully complete emergency medical technician courses. Many of these programs in community colleges use hospital

classrooms as an extension of the college campus.

Financial support for the sophisticated emergency vehicles and the highly trained technicians who man them is beyond the financial means of any private enterprise system currently operating ambulance services. Some means must be found to integrate the EMS vehicles and technicians into a regional EMS, with financial support coming from community, region, state or federal funds, and additional support from payment by patients who are transported by the system. Without the sophistication of the EMS vehicles and technicians described, it is difficult to determine how improvement in mortality rates and mortality from accidents can occur at the next level of EMS care.

CATEGORIZATION OF EMERGENCY MEDICAL FACILITIES

For decades the emergency facilities of most hospitals have consisted of only "accident rooms," poorly equipped, inadequately manned, and ordinarily used for a limited number of seriously ill people or for minority victims of disease or injury.⁹ Society now looks to the hospital emergency department as a community center for outpatient care.

Planning groups should be concerned by the fact that approximately 80 percent of the people utilizing emergency departments are people without emergencies. The great percentage of emergency department visits results from the diminishing number of physicians in the primary care area. Hospital emergency departments have never sought the role of providing primary care, but they have inherited it by default.

Despite the consumers' dissatisfaction with what they consider to be the indignity of impersonal care rendered by an institution, individual members of society, in their fear, lethargy, financial inability, or ignorance, seek health care by the episodic, and in doing so they look to the emergency department as the only source available.

Over a period of years, hospitals have become the point of entry into

the health care delivery system for about one-third of the United States' population.⁹ For example, of the 40 million emergency room visits during 1966, more than two-thirds cannot be classified as emergencies.

Those people who are responsible for designing an EMS system for a state or region must face two facts. It is a fact that the system providing EMS in most communities needs equipment, staffing and refinement if trauma, "the neglected disease of modern society," is to be controlled. The number of physicians who are experienced in the treatment of multiple injuries is limited. The need for special training in immediate care in the overall direction of emergency departments of a calibre commensurate with that attained by only a few individuals (those in active military field units who care for combat casualties) is obvious. Medical undergraduate schools and residency training programs are generally inadequate in traumatology and mass casualty care.

It is a second fact that until sufficient and separate hospital ambulatory clinics are set up to provide primary medical care, or until sufficient numbers of physicians become available to deliver such care, and to do so during hours other than from nine a.m. to five p.m. on weekdays, emergency medical departments are going to be faced with this dual and wasteful use of resources.

The current dictum that an EMS vehicle should deliver a patient to the nearest emergency unit is no longer acceptable. It is essential that the patient be transported to the EMS facility which is best prepared to handle his particular problem. In the absence of a descriptive categorization of the level of care that might reasonably be expected at a facility, neither the patient nor the EMS vehicle personnel can judge which facility is adequate to the immediate need.

Basic to the concept of categorization is the recognition that all hospitals in a community or region need not have equal EMS capability. Although all should provide life-support services, it would be unrealistic

to expect all emergency departments to be manned 24 hours each day by board certified surgeons.

However, it is usually taken for granted by the general public that every emergency room can render full care for injuries of all magnitudes. That the public be thoroughly informed of the extent of care that can be administered at EMS facilities at various levels of competence is an obligation to the severely injured patient as well as to the lone physician, to the small staff of remote hospitals, and to institutions with minimal emergency department facilities. A categorization of EMS facilities would serve to indicate the level of care that a patient can reasonably expect (Figure 1).

Hospital EMS departments should be surveyed in the various regions designated to determine the numbers and types of EMS facilities necessary to provide optimal emergency treatment for the population of each region. Provisions must be made for expected changes in the population for the next few decades. When the required number and types of treatment facilities have been determined, it may be necessary to lessen the requirements of some institutions, increase them in others, and even redistribute resources to support space, equipment, and personnel in the major EMS facilities. Until patients, EMS vehicle personnel, and hospital staffs are in accord as to what the patient might reasonably expect and what the staff of an EMS facility can realistically be expected to administer, and until effective transportation and adequate communications are provided to deliver accident victims to proper facilities, our present levels of knowledge cannot be applied to achieve optimal care, and little reduction in mortality or lasting disability can be expected.

In North Carolina the Medical Care Commission¹¹ has proposed the following levels of categorization for EMS facilities. In an opinion from the Attorney General of North Carolina (See Appendix A) the Medical Care Commission does have authority to categorize hospi-

Category	Scope of Capabilities		Emergency Services Department Staffing				Hospital Staffing	Support Services							
	Immediate Care	Types of Emergencies	Full Time Director MD	Admin Personal Data Collection	Other MD's	Nurses	MD	Consultants	Blood Bank	Lab Services	Radiology	Angiography	OR	Recovery Room	Intensive Care
I Comprehensive Emergency Center	Yes	1*	Yes	Yes	1**	Yes	1**	On Call	In ER	In Hosp	In Hosp	In Hosp	Ready and Staffed	Ready and Staffed	Ready and Staffed
II General Emergency Center	Yes	2*	Yes	Yes	1**	Yes	1**	On Call	In ER	In Hosp	In Hosp	In Hosp	Ready and Staffed	Ready and Staffed	Ready and Staffed
III Intermediate Emergency Center	Yes	3*	-	Yes	2**	Yes	2**	On Call	In ER	In Hosp	In Hosp	-	Readily Available	Readily Available	Ready and Staffed
IV Limited Emergency Center	Yes	4*	-	Yes	3**	Yes	3**	On Call	In Hosp	In Hosp or on Call	In Hosp	-	Readily Available	Readily Available	-
V First Aid Emergency Center	Yes	5*	-	Yes	3**	Yes	3**	On Call	In Hosp	In Hosp or on Call	In Hosp	-	-	-	-

Figure 1. Suggested Guidelines for Categorization of Hospital Emergency Services (10,11).

* See Scope of Care

** 1 = More than two years of residency training and on duty in ER.

** 2 = More than one year of residency training and on duty in ER.

** 3 = Twenty-four hour staffing by qualified personnel on premises or on call.

tals as it proposes under current statutes in the State of North Carolina. The proposed categories of EMS facilities in North Carolina are outlined as follows:

Type I—Comprehensive emergency center

Facilities: Fully equipped to render complex and comprehensive emergency care on the premises, as well as any required definitive care. Diagnostic facilities constantly available for even the most specialized procedures. Blood bank available. Ready accessibility to special purpose operating room.

Staffing: Twenty-four hour staffing by highly qualified medical and hospital support personnel. Ready accessibility to a full range of specialists on a 24-hour basis.

Scope of care: Routinely capable of providing the most advanced surgical and medical procedures including heart lung surgery, kidney dialysis and major plastic surgery. (Such procedures are generally provided only at medical school affiliated hospitals.)

Type II—General emergency center

Facilities: Equipped to render complex emergency care on the

premises. Diagnostic facilities constantly available for most specialized procedures. Blood bank available. Ready accessibility to special purpose operating rooms. Adequate facilities and equipment available to provide services listed in this section under "Scope of care."

Staffing: Twenty-four hour staffing by highly qualified medical and hospital support personnel. Ready accessibility to a broad, but not full, range of specialists on a 24-hour basis.

Scope of care: Routinely capable of providing advanced surgical and medical procedures. Services available include: anesthesiology, general surgery, internal medicine, neurosurgery, obstetrics/gynecology, ophthalmology, orthopedics, pediatrics, psychiatry, radiology, thoracic surgery and urology. One or more highly specialized services, in addition to the services listed, may be offered.

Type III — Intermediate emergency center

Facilities: Equipped for most life-threatening emergencies, but not necessarily providing highly specialized resuscitative and surgical pro-

cedures. In addition to routine diagnostic laboratory and x-ray facilities blood bank is constantly available.

Staffing: Twenty-four hour staffing by qualified personnel on premises or on call but lacking a broad range of specialist services and medical support personnel. Physician coverage sufficient to provide routine medical and surgical services, in the absence of physicians assigned to provide primary coverage.

Scope of care: Equipped to render general medical care and to perform procedures usually included under general surgery. Lacking some specialized diagnostic, medical and surgical procedures. May offer one or more specialized services such as internal medicine, orthopedics, thoracic surgery or urology. Total needs for stabilization or care of the critically ill or injured may exceed the capabilities of facility medical staff and personnel.

Type IV — Limited service emergency unit

Facilities: Same as for Type III—Intermediate emergency center.

Staffing: Normally provides 24-hour staffing by qualified personnel on premises or on call, but lacking

broad range of specialist services and medical support personnel. Differs from staffing of Type III facilities in that professional coverage not available at times when regularly assigned physicians are unable to be in attendance.

Scope of care: Equipped to render general medical care and to perform procedures usually included under general surgery. Lacking in some specialized diagnostic, medical and surgical procedures. Total needs for stabilization or care of the critically ill or injured may exceed the capabilities of facilities and personnel.

Type V — First aid emergency unit

Facilities: Emergency units equipped for only first aid and limited diagnostic procedures.

Staffing: May be limited to part-time professional nursing coverage and part-time physician coverage.

Scope of care: May be limited to minimum procedures such as emergency resuscitation and treatment of minor conditions. Capable of performing procedures such as hemostasis, shock therapy, maintenance of airway and cardiopulmonary resuscitation. Able to provide professional assistance so as to expedite transfer of patients to more appropriate facilities elsewhere if indicated. (All hospitals should be required to furnish this type of service as a minimum.)

THE EMS EMERGENCY ROOM/TRAUMA CENTER

Sophisticated communication and transportation equipment is critically needed for emergency services, but it is of little use if the personnel manning the EMS facility are not competent or trained to render the kind of care required.

The intensive care and continued close surveillance which are necessary to the life-maintenance of a critically ill patient are beyond the scope of the average practicing surgeon or physician.¹ The average practitioner cannot devote the necessary time and involvement required for the long-term intensive management of these patients. Only around-the-clock observation

is available by hospital-based physicians, or by senior surgical and medical residents in training, can a high quality of medical care be continually available.¹¹ Such high quality personnel in these facilities are often eager to manage the difficult problems that are truly beyond the scope of one physician.

At the present, there are many competent medical personnel in the community who perform in an exemplary manner, especially in the acute resuscitation phase. These physicians, unfortunately, have no back-up and they are held responsible for complex problems that are beyond the ability of one physician. The patients in such a situation (who sometimes may require major surgery), after adequate resuscitation, must be transported to facilities having more adequate equipment and staffing.

As a solution to this problem, many states, including North Carolina, are organizing, on a statewide basis, regional EMS systems with specialized trauma centers to be located at the appropriate level of the categorized EMS facilities. The trauma unit proposal, suggesting that such units be located at appropriate levels of the EMS system, should provide an excellent plan for the in-hospital care of the critically injured. The plan of early physical segregation of patients into a specialized area, staffed and equipped to completely resuscitate and evaluate the patient having serious multiple injuries, can be adapted to hospitals of ranging size and potential. Under the plan proposed for North Carolina, trauma centers probably would be located in Types I, II, and III EMS facilities, with Types IV and V delivering the emergency services as described previously. The patient flow through the proposed EMS system is presented in Figure 2.

A solution to this complex problem will require the cooperation of many interest groups and the efficient use of many resources. Of the utmost importance, in instituting an EMS system on a statewide basis, is convincing individual physicians, hospitals, emergency vehicle opera-

tors and, perhaps most important, the general public, that such a system can save many lives and reduce the long-term or permanent disability resulting from trauma.

A satisfactory outcome, after severe traumatic injury, is dependent upon two basic factors: the availability of initial medical care, and the adequacy of those early therapeutic measures. According to Frey et al,¹³ their study showed that 18 percent of 150 accidental deaths might have been avoided with better emergency medical care. Delays in proper resuscitation and evaluation in life-endangering injuries are the crucial indices to survival. Injudicious or inadequate emergency medical management can cause unnecessary fatalities and temporary or permanent disabilities.

RESEARCH AND EVALUATION

The complexities involved in the various aspects of severe injuries, in conjunction with the deficiencies in our health care delivery system, have thus far precluded comprehensive quantitative analysis. Emergency case records are often inadequate. Sufficient thought has not been given to extracting information concerning the nature of the accident; the clinical condition of the patient at the scene of the accident, during transportation, and at the time of entry to the emergency department; the resuscitative measures used; the responses of the patient; the medical laboratory records and x-ray records; and to the ultimate outcome, whether or not it is temporary or permanent disability or death.

This information is vital on several scores. It is essential in re-creating the circumstances of the accident and in relating the mechanisms of trauma to outcome. It is necessary for clinical analysis, for improvement of therapy, and for the assessment of the entire EMS system.

The exact cause of death in many an injured person can be learned only from complete autopsy examinations. Especially in the event of multiple injuries, priority of treat-

ich a system as has been described
this paper. Hopefully, support
ay be obtained when the organiza-
ons and people involved are aware
the necessity for the development
such a system. The medical staffs
hospitals in various regions must
e assured that they will be given
e necessary modern equipment es-
sential to carrying out their tasks.

However, the most important as-
pect of convincing the public and
e hospital personnel that an effec-
ve EMS system is feasible is a
ontinuing surveillance and evalua-
on information system which can
roduce hard data rather than mere
pressions for decision-making.
t the same time, the information
stem should be designed in such a
ay that the continuous surveillance
ll allow modification and changes
take place in the various regional
stems to improve their overall per-
formance. Without a responsible
aluation and surveillance informa-
on system, a statewide EMS system
ems to be an inappropriate use of
e taxpayers' money, as well as the
e of scarce medical resources cur-
ntly available.

This paper is intended as a forum
present problems encountered in
her states and to stimulate some
inking about such an EMS system
the community level. After all, the
ccess of any system of this sort is
ing to require much cooperation
concerned individuals at the local
vel, and unless they are reasonably
ll informed, I seriously doubt that
ch cooperation will be forthcom-
g.

Appendix A

SUBJECT:

Hospitals; Emergency Services; Classi-
fication of Services; Required Services.

REQUESTED BY:

Mr. William F. Henderson
Executive Secretary
The North Carolina Medical Care
Commission

OPINION BY:

Robert Morgan, Attorney General
Harry W. McGalliard, Deputy Attor-
ney General

QUESTION:

Does the North Carolina Medical Care
Commission have authority to classify
hospital emergency services in accord-
ance with types or classifications of
emergency service available, and to re-
quire hospitals to maintain the stand-
ards of emergency care service of the
type or classification which such hos-
pital selects for itself?

CONCLUSION:

Yes, the North Carolina Medical Care
Commission does have authority to
classify hospital emergency services in
accordance with types or classifications
of emergency service available, and to
require hospitals to maintain the stand-
ards of emergency care service of the
type or classification which such hos-
pital selects for itself.

The North Carolina Medical Care
Commission is considering classification
and defining hospital emergency services
according to the types and quality of
service which may be available, perhaps
in five types such as:

- Type I — Comprehensive Emergency
Center
- Type II — General Emergency Center
- Type III — Intermediate Emergency
Department
- Type IV—Limited Service Emergency
Unit
- Type V—First Aid Emergency Unit

Each type would be fully described
with respect to the facilities, staffing,
and scope of care required with respect
to each type of service. Once the classi-
fications were adopted, each hospital
would be expected to designate the type
of emergency services it proposed to
render. The furnishing of the type of
emergency service so selected would be
tied in with the licensing of the hospital
under the Hospital Licensing Act, and
thereafter each hospital would be re-
quired to furnish and maintain the stand-
ards of the type of emergency service
which it elected to render.

The question is whether the North
Carolina Medical Care Commission has
authority to do this under the provisions
of the Hospital Licensing Act. G.S. 131-
126.2 provides as follows:

S. 31-126.2. Purpose—The purpose
of this article is to provide for the
development, establishment and en-
forcement of basic standards:

- (1) For the care and treatment of
individuals in hospitals and
- (2) For the construction, main-
tenance and operation of such hos-
pitals, which, in the light of existing
knowledge, will ensure safe and ade-
quate treatment of such individuals
in hospitals, provided, that nothing
in this article shall be construed as
repealing any of the provisions of
the General Statutes of North Caro-
lina.

G.S. 131-126.3 provides in part as
follows:

After July 1st, 1947, no person or
governmental unit, acting severally
or jointly with any other person or
governmental unit shall establish,
conduct or maintain a hospital in
this State without a license.

The above statutory provisions con-
stitute an adequate grant of authority
from the General Assembly for the North
Carolina Medical Care Commission to
carry out such a program with respect
to hospital emergency services as is de-
scribed above.

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and twenty-first, are, by some authors, denominated critical days, because febrile complaints
have been observed to take a decisive change at these periods.—William Buchan: *Domestic
Medicine, or a Treatise on the Prevention and Cure of Diseases by Regimen and Simple Medi-
cines, etc.*, Richard Folwell, 1799, p. 474.

Drug Deaths in North Carolina: A Brief Survey of Deaths Attributed to Drugs in North Carolina, 1973

Arthur J. McBay, Ph.D.* and Page Hudson, M.D.†

THERE is rapidly growing interest and concern about drug and other chemical hazards, if questions of this office from professional groups and individuals are any measure. The queries are probably well directed, since death is a finite measure of hazard and the Medical Examiner System is responsible for the determination of the cause and manner of death for any person who dies in circumstances indicating possible accident, suicide, homicide or absence of medical care. Included are all deaths directly, and most deaths indirectly, caused by drugs.

It is important to try to distinguish between "drug deaths" and "drug-related deaths." We define the former as the effect of a drug in an inappropriate quantity being the proximate cause of death. Examples include ingestion of 20 propoxyphene capsules and fatal aspiration pneumonia as a result of ingestion of a handful of secobarbital capsules

—even after the barbiturate has disappeared from the system. Drug-related deaths include occurrences such as one heroin pusher's shooting another who is crowding in on his "territory" and the pedestrian with a blood alcohol of 300 mg/dl staggering across the road and being struck by an automobile.

The data presented in this brief survey represent close approximations of reports from the Toxicology Laboratory of the Office of the Chief Medical Examiner (Table 1) and preliminary reports from the Vital Statistics Section of the Division of Health Services.¹

Alcohol is the principal agent in drug deaths and in drug-related deaths in North Carolina and in the rest of the nation. Approximately one-half, or 175, of North Carolina's deaths from poisons in 1973 resulted from acute ingestion of large quantities of alcohol (500-1,000 ml of 50 percent ethanol) within a short period of time. The number of alcohol-related deaths is much greater and includes the disease states brought on by alcohol—liver disease, pancreatitis, central nervous system damage, and others. Also included are the majority of auto crash deaths, fatal shootings and stabbings, drownings, deaths in fires, and

deaths from suicidal or accidental overdosing with other drugs while the person is under the influence of alcohol. We conservatively estimate that there are at least 3,000 alcohol-related deaths in North Carolina each year. The total number of deaths in North Carolina for 1973 was approximately 47,000. Only four deaths were attributed to isopropyl (rubbing) alcohol, and four to methanol (wood alcohol). No deaths were attributed to lead from alcohol or from any other source. Dr. Chafetz, Director of the National Institute of Alcohol Abuse and Alcoholism has commented, "Be whatever standard we weigh the drug situation, number of users, abusers, availability, dollar value, death, disease, destruction, shattered lives—alcohol is number one."²

Barbiturates killed 35 people in 1973 and continue to be directly responsible for the largest number of medicinal drug deaths in North Carolina and in the rest of the United States. Nearly all of these deaths have resulted from patient purposefully taking an overdose of secobarbital, pentobarbital or amobarbital which they obtained legally by prescription. Of the rapid-acting barbiturates, a fatal dose for an adult is approximately one gram

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Table 1
Toxicological Findings in Medical Examiner Cases—1973*

BLOOD VOLATILES		
Ethanol		
(mg/dl)	Number of Cases	
Total Negative	3,301	
0-90	452	
0-190	727	
0-290	620	
0-390	273	
0-490	87	
0-	29	
Total Positive	2,188	
Other Volatiles		
	Number of Cases	
Isopropanol	4	
Formaldehyde	3	
Ethanol	3	
Solvents	5	
Isobutane	1	
Embalming fluid	115	
Total	131	
Total Volatiles	5,620	
CARBON MONOXIDE		
Percent	Number of Cases	
0-10	266	
0-19	30	
0-29	11	
0-39	9	
0-49	12	
0-59	14	
0-69	15	
0-79	37	
0-89	40	
+	3	
Total	437	
BARBITURATES		
Type	Number of Cases	
Rapid-acting:		
Amobarbital + Secobarbital	7	
Pentobarbital	6	
Secobarbital	4	
Amobarbital	2	
Pentobarbital + Butobarbital	1	
Pentobarbital + Secobarbital	1	
Barbitabital + Amitriptyline	1	
Secobarbital + Propoxyphene	1	
Secobarbital + Ethchlorvynol	1	
Subtotal	24	
Secobarbital	10	
Secobarbital + Propoxyphene	1	
Total	11	
Total	35	
OTHER SIGNIFICANT FINDINGS		
Type	Number of Cases	
Propoxyphene	21	
Ethchlorvynol	6	
Salicylate	6	
Amitriptyline	4	
Heroin	4	
Meprobamate	3	
Methimide	3	
Quinidine	2	
Phenetic	2	
Flordazone	2	

Quinidine	2
Methadone-related	2
Amphetamine	1
Imipramine	1
Phosphorus	1
Methaqualone	1
Pentazocine	1
MDA	1
Morphine	1
Total	64
TOTAL MEDICAL EXAMINER CASES	5,628

* These totals represent the number of cases in which a sufficient amount of a drug or chemical was found to be the primary cause of death in the cases submitted to the Toxicology Laboratory. The exceptions to this may be: less than 30 mg/dl of ethanol, less than 30 percent of saturation of carbon monoxide and embalming fluid. Alcohol, when present with other drugs, is recorded as the other drug with no mention of alcohol.

(10-100 mg doses); approximately four grams of phenobarbital is a fatal dose. Analysis of individual case records suggests that possibly the prescription of fewer capsules and the less toxic phenobarbital, diazepam, or chlorthalidone would reduce the hazard. The Drug Enforcement Administration has called the rapid-acting barbiturates more dangerous than heroin. These drugs have been rescheduled from schedule III to II in the Controlled Substances Law.³

Accidental and suicidal deaths from overdoses of propoxyphene have increased greatly in North Carolina and in many other communities in the past two years. Most of these deaths have been caused by propoxyphene hydrochloride (Darvon®), not the newer Darvon-N® or the still newer generic forms of propoxyphene hydrochloride. It is unfortunate that the efficacy of this drug as an analgesic has been so seriously questioned and is so toxic. Ingestion of approximately 1,300 mg (20-65 mg doses) may cause the death of an otherwise healthy adult. The dangers of this drug were not fully appreciated until recently because of difficulties in detecting and quantitating it in blood and tissues. Superior methods are now available for analysis. Twenty-one deaths in 1973 were attributed to propoxyphene in North Carolina.

Although alcohol and barbiturates have been, and apparently continue to be, the major problem drugs in North Carolina and in most of the country, heroin and other illicit drugs are receiving the attention of

the government in drug abuse prevention. Heroin, however, is relatively new to North Carolina, as to most communities. The first known heroin death was identified in this state in 1969. Seventeen heroin deaths were identified in 1971 and 20 were identified in 1972. In keeping with the diminished number reported from many parts of the country, only four heroin deaths were recorded in North Carolina in 1973; one of those who died had recently come from New York and another was a Vietnam veteran.

The mechanism of heroin deaths is unknown. In most cases the victim dies rapidly after the injection of a solution prepared from a combination of two to five percent heroin and diluents. Although the victim in each case has used heroin before and should be tolerant, he dies within a matter of minutes. A small amount of morphine is detected in the blood and no other cause of death is found. The major medical problems with heroin deaths are those caused by nonsterile injections of a drug of unknown strength and quality. We have not identified any deaths caused by the major medical complications of chronic heroin abuse, such as bacterial endocarditis or viral hepatitis. During 1973 methadone contributed to, but was not the single proximate cause, of two deaths. MDA (methylenedioxy-amphetamine) accounted for one death, as did a suicidally inflicted morphine injection.

Salicylates accounted for six deaths during 1973. Most of these were not accidental overdoses in infants, as might be expected, but rather, they were intentional overdoses by middle-aged women. Ethchlorvynol (Placidyl®) caused solely and in combination with other drugs the deaths of six people; amitriptyline, four; meprobamate, three; paraldehyde, three; and Doriden®, two. Drugs known to account for only one death included pentazocine (Talwin®), methaqualone, and imipramine.

Fewer than ten percent of the drug deaths in 1973 could be related to illegally obtained drugs. More than 90 percent of the drugs in-

volved in drug deaths are either controlled drugs or over-the-counter preparations.

Cyanide accounted for two deaths in this state in 1973, and arsenic caused two. Carbon monoxide deaths are not included in this survey of drugs and poisons.

A small but significant group that deserves special mention is the six deaths caused from "sniffing" solvents and propellants, characteristically done among teen-agers for "kicks" or "highs." These deaths include those who intentionally inhaled the Freon propellant from aerosol cans and one who sniffed trichlorethylene from plastic cement. There is a tendency for the public to hold teen-agers responsible for the prevalence of drugs and to believe that drugs are the cause of violent teenage deaths. Our 1972 review of teenage deaths (ages 15-19 years) revealed that of the total 705 deaths, 11 were caused by drugs, including two by alcohol and three by barbiturates. Most of the teen-age deaths were caused by motor vehicle crashes (312), firearms (84), and drownings (55). The majority of these deaths occurred while the teen-age victim was under the influence of alcohol. No one has been able to validly attribute a death in North Carolina to the direct toxic effects of LSD (lysergic acid diethylamide) or to marihuana; in deaths alleged to have been indirectly attributable to these drugs, significant quantities of alcohol have been found on toxicological examination. In the world of

scientific literature, fewer than three or four deaths have been reported to be directly caused by the toxic effects of LSD; there is one dubious case attributable to marihuana. Most toxicologists and forensic pathologists are skeptical of reports of deaths caused by these two drugs.

Nine children, ages one to four years, were killed by drugs and poisons in 1972. Two deaths were caused by each of the following: salicylates (aspirin), pesticides and petroleum products. One death was caused by each of the following: cleaner, cardiac depressant and other poison.

A review of the death statistics in North Carolina for 1972, the latest available, reveals that 5,269 deaths of the approximate total of 47,175 are attributed to poisonings, accidents and violence. Motor vehicle traffic accidents killed 1,943 people, 1,143 died of firearm injuries, 365 died of falls, 242 were killed in fires and 199 drowned. Our experience indicates that alcohol was influential in at least half of these 3,885 deaths. Alcohol intake and alcohol-related diseases accounted for 1,423 deaths. More than 3,000 deaths were related to alcohol, and approximately 100 deaths could be attributed to other drugs.

The medical profession must assume the major role in solving the drug problems. Its members must not contribute adversely to the problems by personally abusing drugs. Great care should be exercised in prescribing psychoactive substances.

Barbiturates should be prescribed in small amounts, avoiding, when possible, the rapid-acting barbiturates or substituting other drugs for them. The need to prescribe propoxyphene should be carefully evaluated in view of its toxicity. The treatment of alcohol abuse and alcoholism should be strongly advocated by the physician. Finally, the medical profession must be a source of the correct drug information.

CONCLUSIONS

The great majority of drug deaths other than those resulting from the use of alcohol, are deaths of adults who ingest overdoses of legally obtained drugs. A very small minority of young people die as a result of the abuse of illegal drugs and solvents.

Nine children were fatally poisoned by drugs or chemicals in 1972.

The majority of teen-age deaths are accidental; they are caused by motor vehicle accidents, the use of firearms and drowning; most of these deaths are alcohol-related. Approximately one percent of teen-age deaths is caused by the abuse of illegal drugs.

Marihuana-related deaths have not been found.

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Air may be many ways rendered noxious, or even destructive to animals. This may either happen from its vivifying principle being destroyed, or from subtle exhalations with which it is impregnated. Thus air that has passed through burning fuel is neither capable of supporting fire nor the life of animals. Hence the danger of sleeping in close chambers, with charcoal fires. Some indeed, suppose the danger here proceeds from the sulphureous oil contained in the charcoal, which is set at liberty and diffused all over the chamber; while others imagine it is owing to the air of the room being charged with phlogiston. — *William Buchan: Domestic Medicine, or a Treatise on the Prevention and Cure of Diseases by Regimen and Simple Medicines, etc.*, Richard Folwell, 1799, p. 413.

To Commit or Not to Commit, A Continuing Dilemma: Some Guidelines

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COMMITMENT of patients, against their will, to mental hospitals, remains a confusing and controversial issue. Increasingly, possible violations of the constitutional rights of the individual are scrutinized, and the courts are challenging hospital commitments that, in the past, were effected without difficulty. Physicians are more and more cautious about being the agency of someone's forcible hospitalization, and the courts are asserting that commitment to a hospital is a medical problem.

Individuals such as Thomas Szasz,¹⁻³ basing their claims on the principles of civil rights and individual freedom, contend that no one should ever be forcibly hospitalized, even if he intends to kill himself, and that persons dangerous to themselves or to others should be dealt with under the laws they are violating. Szasz⁴ considers any form of mental hospitalization to be imprisonment. For others, commitment has traditionally functioned as a multipurpose remedy. It has been used not only to prevent breaches of the peace and harm to persons and property, but also to provide for the treatment and rehabilitation of the mentally ill, to relieve a family of

the responsibility for the care of a disabled member, and to provide a refuge for the destitute, the aged, the mentally deficient, the maladjusted and the maladapted who are not welcome by society. There are, of course, positions between those two extremes, such as that taken by McGarry and Greenblatt⁵ at the Massachusetts Mental Health Center.

The physician is faced with the practical problem of caring for the patient as well as being sensitive to the demands of the family and community. When these two points of view conflict, he finds himself in a painful dilemma. Physicians share the reluctance of many Americans to hospitalize a patient against his will, but they are aware that others favor still more flexible criteria for involuntary hospitalization, since commitment of a dangerous person not only may be necessary for the patient and the community, but may prevent the former's condition from deteriorating.⁶ This latter view becomes even more persuasive when the patient clearly lacks the capacity to make responsible decisions.

The North Carolina State laws enacted by the General Assembly in May 1973⁶ describe new procedures for both voluntary and involuntary admission to inpatient facilities for the treatment of persons with mental illness, alcoholism or drug dependency. In this paper we do not

intend to extensively review these new laws, but rather we propose to examine the specific modalities and some of the clinical circumstances under which involuntary commitment procedures may be carried out. We hope to establish some guidelines for the physician to deal with commitment problems in a humane and rational manner, especially when he does not have the benefit of prompt legal advice or psychiatric consultation.

COMMITMENT LAWS

Two types of involuntary hospitalization are now available in North Carolina: (1) emergency hospitalization, and (2) judicial hospitalization. The emergency procedure is initiated by a law enforcement officer who regards the patient as "violent and of imminent danger to himself or others." The officer is required to bring such an individual before a magistrate who determines whether the patient is to be hospitalized. At the mental health facility, this patient must be examined by a physician who is to notify the magistrate of his findings within 24 hours.

Under judicial hospitalization, a person is taken to a physician (one who is licensed to practice medicine in North Carolina) by a law enforcement officer. If the physician finds that the person, after his examination (on the basis of specific,

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identifiably overt acts), is "violent and of imminent danger to himself or to others," or "gravely disabled," the individual is to be taken to an appropriate mental treatment facility. Within 24 hours of his examination, the physician must submit to the magistrate a written statement of his findings. "Gravely disabled" means that, because of mental illness or inebriety, the patient is unable to "provide for basic personal needs for food, clothing or shelter."

In addition to the procedures for involuntary hospitalization mentioned above, the new laws have changed the modalities for voluntary admission to mental health facilities. It is no longer necessary for a person to have a written statement from a physician recommending that he be admitted. The person may now present himself for admission for mental illness, alcoholism or drug dependency. At the facility itself he is to be examined within 24 hours of his admission by a staff person who will determine whether he is in need of further hospitalization. Because the new laws have changed the modalities for voluntary and involuntary hospitalization, the physician's main task is to determine whether the patient whom he has examined warrants involuntary hospitalization.

The new law emphasizes that physicians, in determining the need for involuntary hospitalization, take into account *overt acts*. Implicit too, in this procedure, is the observation of relatively *sudden changes* in the person's behavior. Thus, a patient who, for years, has made suicidal gestures would not be regarded as being "of imminent danger to himself" unless something specifically different in his behavior has been observed.

CASE REPORTS AND COMMENTS

The following vignette appropriately satisfies the law as described in the preceding paragraph.

Case 1

A 39-year-old Negro man with one previous hospitalization for schizophrenia was functioning ade-

quately as a science teacher. After the assassination of Martin Luther King, he developed the belief that his "brain was wired to an electrical device that might explode any minute," destroying himself and his family. He said that he was going to shoot himself to prevent this catastrophe. He refused voluntary hospitalization because "this might endanger other patients." One week after forced hospitalization and treatment, he was no longer suicidal. He was discharged in six weeks, and six months later he was able to work in the school as a clerk.

In the following case, commitment was clearly indicated; however, when the patient changed her mind and agreed to remain in the general hospital, the necessity of transferring her to a mental health facility became questionable.

Case 2

A black, alcoholic woman on welfare, separated from her husband, had several admissions to the hospital. She wished to leave before her dangerously high blood pressure was controlled. She had a history of leaving the hospital against medical advice, and, although her thinking was not impaired, her current behavior was seen as "psychopathic"; she was to be sent to a state hospital on an emergency certificate. She offered to remain in the general hospital, but commitment was carried out notwithstanding.

In the past, emergency commitments were frequently abused, and were carried out for a variety of reasons. The new law, emphasizing examination of the patient within 24 hours of admission to a mental health facility, should militate against these abuses.

A patient may not pose an immediate danger to himself or to others, as a suicidal or homicidal risk; however, because of defective or deranged thinking, he may be in danger of being "gravely disabled" as in the following case.

Case 3

A 68-year-old man was noted by his neighbors to have become aloof and to be acting strangely. They

called a physician to examine the patient after he refused to make an office visit. The physician found that the patient was malnourished, confused and totally unreasonable in regard to his own condition. There was evidence of moderately advanced arteriosclerosis and possible congestive heart failure. When hospitalization or further examination was suggested, the patient became angry and for several days he barricaded himself with a shotgun, refusing any form of communication or help. Commitment was indicated, since, without prompt medical care, this man's life was endangered.

In the following brief case histories we shall present what occurred at the time the patient was seen by a physician and evaluate the procedure undertaken.

Case 4

A middle-aged, poor, black man was being followed-up in a clinic for headache, weight loss, insomnia and general lassitude. Part of his condition dated back to the time his wife died and he was left to care for five difficult children. He was hospitalized in a general hospital where an arteriogram was read as negative and his symptoms were attributed to depression. Out-patient treatment was of little benefit and he refused psychiatric hospitalization, pleading the need to care for the children. The clinical staff did not move toward commitment. His condition worsened and he died in unclear circumstances. Suicide was not proved but his death wishes were indisputable.

In retrospect, more active intervention was necessary. The patient was seen as hopeless, and sympathy for his devotion to his children prevented the physicians from taking the proper position—insistence on hospitalization, even if the patient refused.

Case 5

An elderly white man, who has always been impulsive, periodically became violent. As mild dementia set in, his control became poor and his wife could no longer tolerate his assaults. After he threw her to the floor, inflicting multiple fractures,

was hospitalized on a general medical ward for some minor medical problems. He was committed at the urging of his children. At this point, he agreed to place his wife in a nursing home. At the mental health facility, it was the opinion of the staff that he could safely live apart from his wife since his impulsive behavior was directed at only her.

In this case, involuntary hospitalization served to protect the wife from her husband's assaults, but it also led him to provide for her placement in a nursing home. However, it was obvious that the staff did not have considerable sympathy for his wife. Consideration of social and family situations can obscure a situation by arousing feelings which may result in the neglect of the patient's well being or in an inappropriate disposition.

When family units are treated as a whole, the relationship between the physician and his patient may become confused. In such instances, assessment of the whole situation may be difficult.

Case 6

A middle-aged, black, alcoholic man with liver disease (quiescent at the time) was brought to the clinic several times by her sister, requesting that she "be committed." The sister was hardworking and realistic. Her family life was disrupted by the patient's frequently seeking refuge in her house after bouts of excessive drinking. The patient had exhibited such a pattern of childish and provocative behavior for several years. The sister pleaded, "He needs to go in — she had been there, you know."

The staff was supportive of the sister and condemning of the patient. When a psychiatric consultant challenged both the previous hospitalization and the need for it now, the staff and the sister grew angry with him. Clearly, the patient was a nuisance and everyone wanted her "tied away." However, there was no noticeable change in her behavior as she did not exhibit overt behavior that would, according to the

new law, indicate the need for involuntary hospitalization.

It is important that physicians not allow the genuine or fantasied distress of a family to lead them to hospitalize a patient. At times, a family member may take advantage of a physician's own irritation with a provocative, uncooperative individual. But patients of this sort often have been behaving in this manner for many years, with no physical violence to themselves or to those around them. Involuntary hospitalization in these cases will lead only to a patient's prompt discharge from the mental health facility. Some effort to deal with the family as a group might prove to be more rewarding.

The physician should avoid taking over the responsibility that the patient's family should rightfully bear. When the physician does assume this responsibility, it only evokes the patient's hostility. Consequently, the patient feels punished, and the physician is placed in the position of being an agent of the family. Effectiveness in serving the family is ultimately reduced since they may feel guilty for having manipulated the physician into a role they know is their responsibility. Supporting the family in order to allow them to make a reasonable decision should be differentiated from taking things out of their hands.

Case 7

Several members of a family reported that a son had been threatening violence off and on and that he would periodically drink excessively. In the past he had harmed a sister and had served a prison term for disorderly conduct. Involuntary hospitalization was carried out although he was then only mildly intoxicated.

In this case, commitment is open to question; if contested, the burden of proof is on the physician who declared this patient "suddenly" homicidal.

Case 8

A middle-aged white man moved toward a window and talked about jumping out. He was known to have

papilledema from an operable brain tumor. He was involuntarily hospitalized. When he arrived at the state hospital he was disoriented, but quiet, and expressed no intent to harm himself or anyone else. Later, he developed some difficulty in moving one side of his body and was transferred to another hospital.

In retrospect, it appears that this patient should not have been hospitalized involuntarily. Admission to a general hospital would have been more appropriate.

Although the appearance of the patient, on his own behalf, before a court of law is recommended by legal authorities mindful of the protection of individual constitutional rights, such a procedure may, at times, prove detrimental to the mental health of the patient. A GAP (Group for the Advancement of Psychiatry) report⁷ recognizes the traumatic effects of a "personal notice" served on the mentally ill.

Case 9

A middle-aged male worker, with a documented history of manic-depressive episodes, was placed in the hospital following bizarre behavior indicative of poor judgment. Although the patient was at first forcibly detained, his physician was able to establish a good relationship with him. The patient wished to stay longer to stabilize his treatment on Lithium; however, during a court procedure where he was released, he became angry and decided to leave the hospital. Later he inflicted injury on himself, necessitating a surgical hospitalization.

This case is cited to induce physicians to seek appropriate changes in the law that would not only guarantee the patient's civil rights, but would protect his well being.

The preceding clinical vignettes were chosen to illustrate some of the typical problems that confront the physician who is called upon to examine a patient who might undergo involuntary hospitalization. The critical issue appears to be that the examining physician must try to maintain his role as a physician and avoid being put in the position of

either a "friend of the family" or a law-enforcement agent.

If he bases his statement on the presence of the patient's recent overt behavior, indicating that the patient is indeed dangerous to himself or others, or is "gravely disabled," then the physician will not only be following the law in its letter and spirit, but will be usefully serving as the patient's physician by proceeding to an involuntary hospitalization.

SUMMARY

Involuntary hospitalization, when exercised judiciously, is an effective and humane method of dealing with

people who have certain forms of mental illness. It has, however, been increasingly questioned as denying patients the due process of law. The new North Carolina laws relating to commitment clarify the role of the physician and define the limits of his duties and responsibilities. In this paper we have described these laws and presented several clinical vignettes that illustrate how involuntary hospitalization should and should not operate.

Acknowledgment

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When the patient is in danger of being immediately suffocated, and all hope of freeing the passage is vanished, so that death seems at hand, if respiration be not restored, the operation of bronchotomy, or opening of the wind-pipe, must be directly performed. As this operation is neither difficult to an expert surgeon, nor very painful to the patient, and is often the only method which can be taken to preserve life in these emergencies, we mention it, but it should only be attempted by persons skilled in surgery.—*William Buchan: Domestic Medicine, or a Treatise on the Prevention and Cure of Diseases by Regimen and Simple Medicines, etc.*, Richard Folwell, 1799, p. 410.

Is He a Source of Information?

Yes, with certain reservations. The average sales representative has a great fund of information about the drug products he is responsible for. He is usually able to answer most questions fully and intelligently. He can also supply prints of articles that contain a great deal of information. Here, I exercise some caution. I usually accept most of the statements and opinions that I find in the papers and studies which come from the larger teaching facilities. I do so without saying that a physician should also rely on other sources for his information on pharmacology.

Training of Sales Representatives

Ideally, a candidate for the position as a sales representative of a pharmaceutical company should be a graduate pharmacist who has a questioning mind. I don't think this is possible in every case, and so it becomes the responsibility

of the pharmaceutical company to train these individuals comprehensively. It is of very great importance that the detail man's knowledge of the product he represents be constantly reviewed as well as updated. This phase of the sales representative's education should be a major responsibility of the medical department of the pharmaceutical company.

I am certain that most of these companies take special care to give their detail men a great deal of information about the products they produce—information about indications, contraindications, side effects and precautions. Yet, although most of the detail men are well informed, some, unfortunately, are not. It might be helpful if sales representatives were reassessed every few years to determine whether or not they are able to fulfill their important function. Incidentally, I feel the same way about periodic assessments of everyone

in the health care field, whether they be general practitioners, surgeons or salesmen.

Value of Sampling

I personally am in favor of limited sampling. I do not use sampling in order to perform clinical testing of a drug. I feel that drug testing should rightly be left to the pharmacology researcher and to the large teaching institutions where such testing can be done in a controlled environment.

I do not use samples as a "starter dose" for my patients. I do, however, find samples of drugs to be of value in that they permit me to see what the particular medication looks like. I get to see the various forms of the particular medication at first hand, and if it is in a liquid form I take the time to taste it. In that way I am able to give my patients more complete information about the particular medications that I prescribe for them.

capacity they are indeed useful; particularly in the fact that they disseminate broadly based educational material and serve not just as "pushers" of their drugs.

The Other Side of the Coin

Obviously, the pharmaceutical companies are not producing all this material as a labor of love—they are in the business of selling products for profit. In this regard the ambitious and improperly motivated sales representative can exert a negative influence on the practicing physician, both by presenting a one-sided picture of his product, and by encouraging the practitioner to depend too heavily on drugs for his total therapy. In these ways, the salesman has often distorted objective reality and undermined his potential role as an educator.

The Industry Responsibility

Since the detail man must be an information resource as well as a representative of his particular pharmaceutical company, he should be carefully selected and

thoroughly trained. That training, perforce, must be an ongoing one. There must be a continuing battle within and with the pharmaceutical industry for high quality not only in the selection and training of its sales representatives, but also in the development of all of its promotional and educational material.

The industry must be ready to accept constructive as well as corrective criticism from experts in the field and consumer spokesmen, and be willing to accept independent peer review. The better educated and prepared the salesman is, the more medically accurate his materials, the better off the pharmaceutical industry, health professionals and the public—i.e., the patients—will be.

Physician Responsibility

The practicing physician is in constant need of up-to-date information on therapeutics, including drugs. He should and does make use of drug information and answers to specific questions supplied by the pharmaceutical representative. However, that informa-

tion must not be his main source of continuing education. The practitioner must keep up with what is current by making use of scientific journals, refresher courses, and information received at scientific meetings.

The practicing physician not only has the right, but has the responsibility to demand that the pharmaceutical company and its representatives supply a high level of valid and useful information. I feel certain that if such a high level is demanded by the physician as well as the public, this demand will be met by an alert and concerned pharmaceutical industry.

From my experience, my impression is that sectors of the pharmaceutical industry are indeed ethical. I challenge the industry as a whole to live up to that word in its finest sense.

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Editorials

A NEW EDITOR

For the first time in my 11 years as editor of this JOURNAL, I am abandoning editorial anonymity to write a more personal note to all of you concerning the JOURNAL's past and future, and especially its new editor.

Dr. Wingate Johnson founded the JOURNAL in 1941, and he called me about some JOURNAL business a few minutes before his death in September 1963. He was a great editor, from a family of notable literary talent. He was supported by his editorial boards and the Society in a wholehearted way. The JOURNAL's history had not been entirely without criticism, but that too is a good sign and is better than going unnoticed. During the interregnum, when the Society was deciding what to do about the JOURNAL and the editorship, I too was pondering the matter, should I be asked to succeed Dr. Johnson from my post as acting editor. As everyone else, and maybe more than most, since I have the pathologist's task of keeping up with medicine generally, I had to question whether a state journal was worth supporting. You can guess that I thought it was, and my reasons are reflected in the statement of the JOURNAL's objectives which appear in every January and July issue's "Instructions to Authors." We have our own people and problems here in North Carolina, and the JOURNAL does its part in printing information about them. It is a chronicle of North Carolina medical affairs that has no substitute presently. During my tenure, this view of the JOURNAL's identity has been shared by the fine editorial boards it has had, and by an investigative committee of the House of Delegates.

The editorial board of this JOURNAL has always been one of its strengths, and I have especially appreciated it. Dr. Nicholson brought experience, wisdom and continuity to it. Dr. John Rhodes' eloquent pen and profound knowledge of the Society's activities bring the JOURNAL a dimension lacking in the editor. Other members of the Board have helped with paper reviewing and in setting JOURNAL policy on sticky matters. The headquarters staff manages the business affairs of the JOURNAL with skill and speed.

Now a new editor will take the JOURNAL with the October issue. Dr. John H. Felts, professor of medicine at the Bowman Gray School of Medicine, was elected unanimously by the editorial board after

my wish to resign was brought to their attention. My resignation is prompted by the pressure of other duties, and in no small way by the feeling that it was time for a new view for the JOURNAL. A variety of people was canvassed by the Board in a search for candidates, and Dr. Felts was selected after due process. Since Jack has been in the state for 25 years and a member of the Society since he finished his specialty training in 1955, many of you know him already. Some think of him as a nephrologist, but many know him also as a deeply thoughtful man with wide interests, including nonmedical literature. Some may recall his entertaining "Medical Spectator" columns during Dr. Johnson's editorship. For me, I have been a constant, friendly critic of the JOURNAL and not averse to letting me know when he thought my aim was off. Having thus kept in touch with the JOURNAL over the years, he is especially suited to his task, and I think we are lucky that he consented to take on this addition to his heavy load at the medical school. As for me, I look forward to assuming his role as friendly critic and recommending the same role to all of you.

ROBERT W. PRICHARD, M.D.

THE NEGLECTED DISEASE OF MODERN SOCIETY

"The Neglected Disease of Modern Society" is the "catchy" title of a booklet published under the auspices of the National Academy of Science-National Research Council in 1966.¹ North Carolina is one of the states that have *not* neglected this disease over the past ten years. One of the most active state trauma committees of the American College of Surgeons in the United States became interested in the problem in the early 1960s and developed training programs for ambulance attendants throughout the state. Riding on the crest of this wave of enthusiasm, training programs were established in the community colleges of North Carolina—again, the first state in the nation to make such an effort. In 1967, we were one of the first states to establish a minimal training and vehicle law for transporting the injured. The Committee on Emergency Medical Services of the North Carolina Medical Society has had a lot of influence on these activities, with support when it was most needed. North Carolina now has a State Emergency Medical Services organization under the D

ment of Human Resources. Recruitment of a full-time staff with the best personnel available from throughout the nation is now in its final stages. The people and the Legislature of the state of North Carolina have been aware of the problem in delivery of emergency medical services and have given it their moral and financial support in an appropriate fashion. With recent federal support and guidelines, passage of a bill on emergency medical services and the approval of the military air evacuation system for the public (helicopter), we should expect even more dramatic improvements.

In this issue of the JOURNAL, Dr. Frank Cordle presents a succinct overview of the emergency medical services in North Carolina. He appropriately

concludes his presentation with a challenge to those directing the state emergency medical services for evaluation of their accomplishments. With the continued support of the physicians and the public of a statewide emergency medical service system in North Carolina, we have no doubt that the evaluation will be positive. If you are not familiar with the emergency medical service system in North Carolina and are not actively participating in, or supportive of, the emergency medical service system in your community, we urge you to become involved.

GEORGE JOHNSON, JR., M.D.

References

1. *Accidental death and disability: The neglected disease of modern society.* National Academy of Sciences-National Research Council, Washington, D. C., 1966.

Bulletin Board

NEW MEMBERS of the State Society

Polman, James U., M.D. (N), 210 W. Wendover Ave., Greensboro 27401
 Right, Don Clark, M.D. (Intern-Resident), 3026 Truitt Dr., Burlington 27215
 Cig, John Hamilton, M.D. (AN), Mercy Hosp. Dept. of Anes, Charlotte 28204
 Plard, Dulon Devon, M.D. (P), P. O. Box 411, Smithfield 27577
 Ple, Gordon Joseph, M.D. (R), 901 Goodwood Rd., Winston-Salem 27103
 Rnpulla, Elliott John, M.D. (Intern-Resident), 1304 Watson Ave., Winston-Salem 27103
 Robertson, Merritt Ezekiel, M.D. (GP), Rt. 2, Box 967, Wendell 27591
 Supply, Ben Gordon, M.D. (PD) (Renewal), 1800 W. 10th St., Greenville 27834
 Sale, Walter Franklin, M.D. (GS), Rt. 1, Box 50-CC, Waldese, N. C.
 Thurst, George Monroe, M.D., Catawba Mem. Hosp., Hickory 28601
 Vathan, Gordon Earl, M.D. (PD), (Renewal), 1908 Forest Hill, Greenville 27834
 Vlbacher, David Albert, M.D. (GS), 86 Victoria Rd., Asheville 28801

WHAT? WHEN? WHERE?

In Continuing Education

Note: (1) Programs sponsored by the Bowman Gray, Duke or UNC School of Medicine are approved for "Category 1" AMA Physicians Recognition Award credit, and for AAFP "Prescribed" continuing education credit. (2) "Place" and "sponsor" are listed only where these differ from the place and group or institution listed under "For information."

In North Carolina September 17-19

Rehabilitation of the Patient with Myocardial Infarction—Interdisciplinary Approach

Place: Velvet Cloak Inn, Raleigh

Sponsors: UNC School of Nursing, the Physical Therapy Division of the UNC Medical School's Department of Medical Allied Health Professions, and the North Carolina Heart Association

Fee: Tuition \$75; registration \$25; open to physicians, registered nurses, dietitians, physical and occupational therapists and social workers. Financial assistance available to qualified applicants.

Program: Designed for those involved or to be involved in an organized cardiac rehabilitation program, hence team application is strongly encouraged. Each health team member will learn how to integrate and use pertinent theoretical concepts of rehabilitation in the process of assessment, intervention, and evaluation of patient management.

For Information: Laurice Ferris, Assistant Professor, UNC School of Nursing, Chapel Hill 27514

September 18-19

19th Annual Angus M. McBryde Perinatal Symposium
Fee: \$50.00

For Information: George Brumley, M.D., Division of Perinatal Medicine, P. O. Box 2911, Duke University Medical Center, Durham 27710

September 19-21

Topics in Internal Medicine, the Fourth Annual Seminar in Medicine

Place: Babcock Auditorium

Fee: \$75.00

For Information: Emery C. Miller, M.D., Associate Dean for Continuing Education, Bowman Gray School of Medicine, Winston-Salem 27103

September 20-21

1974 Walter L. Thomas Symposium on Gynecologic Malignancy and Surgery

Program: The two day symposium will be clinically oriented with the main emphasis on "Ovarian Cancer" and "Difficult Office Gynecology."

Invited guest speakers include Herbert Buchsbaum, Iowa City, Iowa, and Dr. J. Taylor Wharton, Houston, Texas. Credit: AAFP credit applied for.

For Information: W. T. Creasman, M.D., Director of Gynecologic Oncology, P. O. Box 2079, Duke University Medical Center, Durham 27710

September 21

Ophthalmology Clinical Grand Rounds

Place: Hornaday Conference Room, Eye Center Building

For Information: Maurice Landers, III, M.D., Box 3802, Duke University Medical Center, Durham 27710

September 25-28

North Carolina Medical Society Annual Committee Conclave

Place: Mid-Pines Club, Southern Pines

Regular meetings will be scheduled for the chairman and members of almost all regular committees of the Medical Society. Committee members should plan to be present if at all possible

For Information: Mr. William N. Hilliard, Executive Director, North Carolina Medical Society, P. O. Box 27167, Raleigh 27611

September 27-29

Invitational Assembly for Advanced Urology—Urinary Calculi and Related Diseases

Place: Pinehurst Hotel, Pinehurst

Fee: \$100

For Information: James E. Glen, M.D., Box 3707, Duke University Medical Center, Durham 27710

October 2

Fifth District Medical Society Meeting

Place: Country Club of North Carolina, Pinehurst

For Information: F. Wilson Staub, M.D., Pinehurst Surgical Clinic, Pinehurst 28374

October 2-3

Fourteenth Annual Charlotte Postgraduate Seminar

Place: Charlotte Memorial Hospital Auditorium

Sponsor: Mecklenburg County Chapter American Academy Family Physicians

Program: Topics will include acute leukemia and solid tumors in children, acute myocardial infarction, difficult EKGs, oral contraception in the female, perimenopausal problems, respiratory emergencies, infectious diseases and difficult lung diseases. Spouses of participants are invited to attend Dr. Gordon Deckert's Wednesday afternoon session, "Transactional Analysis, Concepts, and Sex."

For Information: M. Lawrence Kouri, Jr., M.D., 2028 Woodland Drive, Charlotte 28205

October 2-3

Use of Psychotropic Medicines, The Broughton Hospital Psychiatric Symposium

For Information: Dr. Robert W. Gibson, Jr., Director of Clinical Services, Broughton Hospital, Morganton 28655

PRESCRIBING INFORMATION Antiminth (pyrantel pamoate) Oral Suspension

Actions. Antiminth (pyrantel pamoate) has demonstrated anthelmintic activity against *Enterobius vermicularis* (pinworm) and *Ascaris lumbricoides* (roundworm). The anthelmintic action is probably due to the neuromuscular blocking property of the drug.

Antiminth is partially absorbed after an oral dose. Plasma levels of unchanged drug are low. Peak levels (0.05-0.13 µg/ml.) are reached in 1-3 hours. Quantities greater than 50% of administered drug are excreted in feces as the unchanged form, whereas only 7% or less of the dose is found in urine as the unchanged form of the drug and its metabolites.

Indications. For the treatment of ascariasis (roundworm infection) and enterobiasis (pinworm infection).

Warnings. *Usage in Pregnancy:* Reproduction studies have been performed in animals and there was no evidence of propensity for harm to the fetus. The relevance to the human is not known.

There is no experience in pregnant women who have received this drug.

Precautions. Minor transient elevations of SGOT have occurred in a small percentage of patients. Therefore, this drug should be used with caution in patients with pre-existing liver dysfunction.

Adverse Reactions. The most frequently encountered adverse reactions are related to the gastrointestinal system.

Gastrointestinal and hepatic reactions: anorexia, nausea, vomiting, gastralgia, abdominal cramps, diarrhea and tenesmus, transient elevation of SGOT.

CNS reactions: headache, dizziness, drowsiness, and insomnia. Skin reactions: rashes.

Dosage and Administration. *Children and Adults:* Antiminth Oral Suspension (50 mg. of pyrantel base/ml.) should be administered in a single dose of 11 mg. of pyrantel base per kg. of body weight (or 5 mg./lb.); maximum total dose 1 gram. This corresponds to a simplified dosage regimen of 1 cc. of Antiminth per 10 lb. of body weight. (One teaspoonful = 5 cc.)

Antiminth (pyrantel pamoate) Oral Suspension may be administered without regard to ingestion of food or time of day, and purging is not necessary prior to, during, or after therapy. It may be taken with milk or fruit juices.

How Supplied. Antiminth is available as a pleasant tasting caramel-flavored suspension which contains the equivalent of 50 mg. pyrantel base per ml., supplied in 60 cc. bottles and Unitcups™ of 5 cc. in packages of 12.

ROERIG 

A division of Pfizer Pharmaceuticals
New York, New York 10017

WORMS BLITZED



A single dose of Antiminth (1 cc. per 10 lbs. of body weight, 1 tsp./50 lbs. — maximum dose, 4 tsp.=20 cc.) offers highly effective control of *both* pinworms and roundworms.

Antiminth has been shown to be extremely well tolerated by children and adults alike in clinical studies.* Pleasantly caramel-flavored, it is non-staining to teeth and oral mucosa on ingestion... doesn't stain stools, linen or clothing.

One prescription can economically treat the entire family.

ROERIG *Pfizer*

A division of Pfizer Pharmaceuticals
New York, New York 10017

**Pinworms, roundworms controlled
with a single, non-staining dose of**

ANTIMINTH[®]
(pyrantel pamoate)

equivalent to 50 mg pyrantel/ml.

ORAL SUSPENSION

Data on file at Roerig.

Please see prescribing information on facing page.

October 4

25th Annual Winston-Salem Heart Symposium
Place: Babcock Auditorium, Bowman Gray School of Medicine, Winston-Salem
Fee: \$15.00
For Information: Mrs. Katherine Cox, Forsyth County Heart Association, 2046 Queen Street, Winston-Salem 27103

October 8-10

Cardiac Arrhythmia Course
Place: Orthopedic Clinic Conference Room
Fee: \$75
Credit: 21 hours AAFP credit applied for.
For Information: Galen Wagner, M.D., Box 3327, Duke University Medical Center, Durham 27710

October 18-19

Sixth Annual Orofacial Anomalies Symposium
Enrollment limited to 250 registrants
For Information: Raymond Massengill, Jr., Ed. D., Box 3523, Duke University Medical Center, Durham 27710

October 20-22

Annual Joint Meeting of the North Carolina-South Carolina Societies of Ophthalmology and Otolaryngology
Place: Great Smokies Hilton Inn, Asheville, N. C.
Sponsor: The North Carolina Society of Ophthalmology and Otolaryngology
For Information: Banks Anderson, Jr., M.D., Secretary-Treasurer, P. O. Box 3802, Duke University Eye Center, Durham 27710

October 21-22

Institute on Disaster Preparedness
Place: Grove Park Inn, Asheville
Sponsors: North Carolina Hospital Association and the American Hospital Association
Fee: \$65.00
For Information: Mr. Courtland Newman, American Hospital Association, 840 North Lake Shore Drive, Chicago, Illinois 60611

October 28-November 1

Current Concepts in General Radiology
Place: Southampton Princess Hotel, Southampton, Bermuda
Program Chairman: Richard G. Lester, M.D., Professor and Chairman of Radiology, Duke University Medical Center. Guest speakers will include: Robert G. Fraser, M.D., Professor and Chairman of Radiology, McGill University Medical School, Montreal, Canada; John A. Evans, M.D., Professor and Chairman of Radiology, Cornell University Medical College; William B. Seaman, M.D., Professor and Chairman of Radiology, Columbia University College of Physicians and Surgeons, New York, N. Y.; Harold G. Jacobson, M.D., Professor and Chairman of Radiology, Albert Einstein College of Medicine (MHMC), Bronx, New York; and David H. Baker, M.D., Director of Radiology, Babies Hospital, Professor of Radiology, Columbia University College of Physicians and Surgeons, New York, N. Y. Subject matter will cover Pediatric and Adult Radiology of the Chest, Genitourinary Tract, Gastrointestinal Tract and Musculoskeletal System.

Fee: \$200
Credit: Twenty-three hours AMA "Category One" accreditation
For Information: Robert McLelland, M.D., Department of Radiology, Box 3808, Duke University Medical Center, Durham 27710.

November 4-6

Amputations and Prosthetics
Place: Holiday Inn West, Durham
Sponsor: American Academy of Orthopaedic Surgeons, Chicago, Illinois
Fee: \$150
For Information: Frank W. Clippinger, M.D., Box 2919, Duke University Medical Center, Durham 27710

November 7-9

North Carolina Academy of Family Physicians Annual Meeting
Place: Sheraton Crabtree Motor Inn, Raleigh
For Information: North Carolina Academy of Family Physicians, 1602 Wake Forest Road, Raleigh 27603

November 15-16

Anesthesiology Fall Seminar
Place: Charlotte Memorial Hospital Auditorium
Fee: \$40
For Information: Dr. H. A. Ferrari, Chairman, Department of Anesthesiology, Charlotte Memorial Hospital, P. O. Box 2554, Charlotte 28201

December 6-7

What's New in Newborn Care?
Place: Babcock Auditorium
Fee: \$45
Credit: 9 hours AAFP credit
For Information: Emery C. Miller, M.D., Associate Dean for Continuing Education, Bowman Gray School of Medicine, Winston-Salem 27103

December 11-12

Hospital Emergency Room Services and Ambulatory Care
Place: Winston-Salem Hyatt House and Convention Center, Winston-Salem
Sponsors: North Carolina Hospital Association and the North Carolina Medical Society
Program: Designed for hospital administrators, trustees and physicians
For Information: Mrs. Diane Turner, North Carolina Hospital Association, P. O. Box 10937, Raleigh 27605

January 24-25

Surgical Infections
Fee: \$75
Credit: 12 hours
For Information: Emery C. Miller, M.D., Associate Dean for Continuing Education, Bowman Gray School of Medicine, Winston-Salem 27103

Continuing Education for Nurses

October 21-23: Problem-Oriented Medical Record System
October 23-25: The Nursing Audit
November 4-6: The Nurse: Planning Classes for Expectant Parents
November 6: A Practical Approach to Drug Interaction
November 18-22: Planning Patient Care
For Information: Judith E. Wray, Administrative Secretary, Continuing Education Program, UNC School of Nursing, Chapel Hill 27514

Cancer Information by Phone

A toll free phone call to The Southern Medical Association Cancer Education Service (1-800-231-6970), makes cancer information available by phone to physicians in North Carolina and other states in the Southern Medical Association area. Tapes must be requested by number. For a cross indexed list of over 260 tapes, call the above number, identify yourself by name, address, city and state, and request a copy of the index.

New Directory Available

The second edition (OP-414) of the *Directory of Self Assessment Programs for Physicians* is now available for \$1.00 from the Order Department, American Medical Association, 535 N. Dearborn, Chicago, Illinois 60610. The new edition lists six new self-assessment programs in: Allergy, Cardiology, Chest Diseases, Colorectal and Anorectal Surgery, Emergency Medicine, and Neurological Surgery. A total of 21 programs is sponsored by specialty societies, a county medical society and one university. Each program, listed by topic and sponsor, described with regard to: intended participant, sites and time of testing, dates of first test and most recent revision, objectives and content, format, time required, method of scoring, aids to learning provided, fees charged and when to write for further information.

In Contiguous States

September 16-21

Fifth Annual Family Practice Refresher Course
Place: Mills Hyatt House Hotel
Fee: \$140 payable in advance on or before September 9th
Enrollment limited to 75 registrants
Credit: Forty hours AAFP credit approved
The registration fee includes the Social Hour and Banquet

on Wednesday evening, to which wives are cordially invited.

r Information: Vince Moseley, M.D., Director, Division of Continuing Education, Medical University of South Carolina, 80 Barre Street, Charleston, South Carolina 29401

September 19

mposium on the Management of Diabetes Mellitus
onsors: Division of Endocrinology and Metabolism, and the Departments of Family Practice and Continuing Education

edit: Accredited by AMA; 5 $\frac{3}{4}$ prescribed hours AAFP credit applied for

r Information: Dr. H. St. George Tucker, Professor and Chairman, Division of Endocrinology and Metabolism, Medical College of Virginia, Box 111, MCV Station, Richmond, Virginia 23298

September 30 & October 1

ennessee Valley Medical Assembly annual meeting

r Information: Thomas L. Buttram, M.D., Chairman, Tennessee Valley Medical Assembly, Whitehall Medical Center, 960 E. Third Street, Chattanooga, Tennessee 37403

October 5-8

uthern Psychiatric Association annual meeting

ce: The Homestead, Hot Springs, Virginia

r Information: Mrs. Annette Boutwell, P. O. Box 10387, Raleigh 27605

December 5-8

re Curriculum: Clinico-Pathologic Correlations in Cardiovascular Disease

ce: Williamsburg Conference Center, Williamsburg, Virginia

r Information: Miss Mary Anne McInerney, Director, Department of Continuing Education Programs, American College of Cardiology, 9650 Rockville Pike, Bethesda, Maryland 20014

December 6-8

eurologic Problems of Infancy and Childhood

ce: Cascades Meeting Center, Williamsburg, Virginia

onsors: University of Virginia School of Medicine; Medical College of Virginia of Virginia Commonwealth University; Eastern Virginia Medical School

e: \$85

edit: 13 $\frac{3}{4}$ prescribed hours AAFP credit applied for
rollment limited to 80 registrants

Items submitted for listing should be sent to: WHAT? WHEN? WHERE?, P. O. Box 8248, Durham, N. C. 27704, by the 10th of the month prior to the month in which they are to appear.

AUXILIARY TO THE NORTH CAROLINA MEDICAL SOCIETY

AUXILIARY MEMBERSHIP

COMMUNICATION, COOPERATION, EDUCATION, was the theme emphasized by Mrs. Philip Aspell at her installation as the 1974-1975 president of the Auxiliary to the North Carolina Medical Society. "Lofty phrases," you say, "but who are we to communicate *to*, cooperate *with*, and *what* education needed?"

Through the generosity and *cooperation* of your North Carolina Medical Society and the editors of our NORTH CAROLINA MEDICAL JOURNAL, we hope *communicate* with you, the physicians who receive *s journal*—and hope that all of you take the

JOURNAL home to your wives. We hope to *educate* by telling you and your wife about needs in your state and your community, and what the North Carolina Auxiliary can do and is doing to meet these needs.

But before the Auxiliary can be effective, we must have the hands and hearts of physicians' wives throughout North Carolina. Therefore, *membership* has to be the first priority.

The Medical Society membership totals over 4,300; the Auxiliary, 2,800—a gap of 1,500! Even "allowing" for widowers and bachelors, the North Carolina Auxiliary is not reaching many of the physicians' wives whom we need.

More than 98 percent of our members belong to an organized county auxiliary. Some physicians' wives have not joined hands with us, even in those counties which have an available organized auxiliary. We hope that the county auxiliary presidents and membership chairmen will stimulate their interest and encourage membership.

But what about the physicians' wives in counties where there is no auxiliary? Frequently these women have been the first called upon to handle everything health-related in the county—Red Cross blood recruitment, P.T.A. programs, immunization, preschool screening, and drug and venereal disease education. We in the organized auxiliary have the material and manpower to help. Much of this information is already being sent to our members-at-large through our national magazine, *M.D.'s Wife*, our state newspaper, "Tarheel Tandem," and many other mailings.

Perhaps you or your wife says, "I am not interested" in auxiliary work. But, can you say, "I am not interested" in AMA education and research, when last year it brought to our three four-year medical schools 25 percent more than we North Carolinians donated through pro-rated, unrestricted funds? No one can say, "I am not interested" in legislation, when so much has happened because of indifference, apathy and "don't bother me" attitudes. No one can say, "I am not interested" in health education and promoting health careers, when we so desperately need nurses, technicians, and others in the field. We in the Auxiliary *are interested*. We are working actively and effectively to try to fill some of these needs.

The Auxiliary needs the help and support of every physician's wife in North Carolina. Dues are \$4.00 for the state auxiliary and \$4.00 for the national Auxiliary—making a total of \$8.00. From counties with an organized auxiliary, prospective members may send dues to the county auxiliary treasurer. Physicians' wives from counties without an organized auxiliary may become members-at-large by sending dues to: Mrs. Edward P. Benbow, Treasurer, 3809 Friendly Avenue, Greensboro, North Carolina 27410.

JOIN US! Together we can do more!

Next month we will emphasize some of our programs and projects. Communicate with us, and if you find our "Auxiliary Page" worthwhile, let us know.

News Notes from the—

BOWMAN GRAY SCHOOL OF MEDICINE WAKE FOREST UNIVERSITY

The medical school has received a \$39,900 grant from the North Carolina Regional Medical Program as part of a statewide program to provide improved care to arthritis patients. The major emphasis of the program at Bowman Gray will be providing that care outside of the Bowman Gray-Baptist Hospital medical center.

Bowman Gray will run one-day-a-week clinics for arthritis patients at the Family Health Center of Reynolds Memorial Hospital, at the East Bend Community Health Center in Yadkin County and at the Farmington Community Health Center in Davie County.

A registered nurse has been trained by the medical school to provide follow-up care and to do some of the laboratory work patients will need at the arthritis clinics.

Dr. Robert A. Turner, assistant professor of medicine at Bowman Gray, will direct the school's arthritis program in the clinics. He and other physicians, both on the medical school faculty and in private practice, will perform initial examinations on arthritis patients. Although the specially-trained nurse will do the follow-up, she will have the physicians to call upon for back-up.

* * *

Dr. Melvin Levitt, associate professor of physiology, has received a five-year, \$128,388 grant from the National Institute of Neurological Diseases and Stroke to conduct research on pain.

His work is an outgrowth of observations on research animals which had a pain pathway severed. His observations contradict the classical concept of nerve pathways, the classical concept being that pain impulses travel a relatively straightforward line from the site where pain originates to the brain.

Even when the research animals had a pain pathway cut, they continued to exhibit what Dr. Levitt calls "disturbing sensations." He does not know whether the animals are feeling pain in the area of the body served by the cut pathway, but they are feeling something uncomfortable in that area. According to the classical concept, they should not be feeling anything in the area.

* * *

J. Ben Haste has been appointed director of the Medical Center Computer Center. He succeeds Dr.

Rondomycin[®]

(methacycline HCl)

CONTRAINDICATIONS

Hypersensitivity to any of the tetracyclines
WARNINGS Tetracycline usage during tooth development (last half of pregnancy to eight years) may cause permanent tooth discoloration (yellow-gray-brown), which is more common during long-term use but has occurred after repeated short-term courses. Enamel hypoplasia has also been reported. **Tetracyclines should not be used in this age group unless other drugs are not likely to be effective or are contraindicated.**

Usage in pregnancy. (See above **WARNINGS** about use during tooth development.) Animal studies indicate that tetracyclines cross the placenta and can be toxic to the developing fetus (often related to retardation of skeletal development). Embryotoxicity has also been noted in animals treated early in pregnancy.

Usage in newborns, infants, and children. (See above **WARNINGS** about use during tooth development.)

All tetracyclines form a stable calcium complex in any bone-forming tissue. A decrease in tibula growth rate observed in premature given oral tetracycline 25 mg/kg every 6 hours was reversible when drug was discontinued.

Tetracyclines are present in milk of lactating women taking tetracyclines.

To avoid excess systemic accumulation and liver toxicity in patients with impaired renal function, reduce usual total dosage and if therapy is prolonged, consider serum level determinations of drug. The anti-anabolic action of tetracyclines may increase BUN. While not a problem in normal renal function, in patients with significantly impaired function, higher tetracycline serum levels may lead to azotemia, hyperphosphatemia, and acidosis.

Photosensitivity manifested by exaggerated sunburn reaction has occurred with tetracyclines. Patients apt to be exposed to direct sunlight or ultraviolet light should be so advised and treatment should be discontinued at first evidence of skin erythema.

PRECAUTIONS If superinfection occurs due to overgrowth of nonsusceptible organisms, including fungi, discontinue antibiotic and start appropriate therapy.

In venereal disease when coexistent syphilis is suspected, perform darkfield examination before therapy and serologically test for syphilis monthly for at least four months.

Tetracyclines have been shown to depress plasma prothrombin activity; patients on anticoagulant therapy may require downward adjustment of their anticoagulant dosage.

In long-term therapy, perform periodic organ system evaluations (including blood, renal, hepatic).

Treat all Group A beta-hemolytic streptococcal infections for at least 10 days.

Since bacteriostatic drugs may interfere with the bactericidal action of penicillin, avoid giving tetracycline with penicillin.

ADVERSE REACTIONS **Gastrointestinal** (oral and parenteral forms) anorexia, nausea, vomiting, diarrhea, glossitis, dysphagia, enterocolitis, inflammatory lesions (with monilial overgrowth) in the anogenital region.

Skin maculopapular and erythematous rashes, exfoliative dermatitis (uncommon). Photosensitivity is discussed above (See **WARNINGS**).

Renal toxicity rise in BUN, apparently dose related (See **WARNINGS**).

Hypersensitivity: urticaria, angioneurotic edema, anaphylaxis, anaphylactoid purpura, pericarditis, exacerbation of systemic lupus erythematosus.

Bulging fontanels, reported in young infants after full therapeutic dosage, have disappeared rapidly when drug was discontinued.

Blood hemolytic anemia, thrombocytopenia, neutropenia, eosinophilia.

Over prolonged periods, tetracyclines have been reported to produce brown-black microscopic discoloration of thyroid glands; no abnormalities of thyroid function studies are known to occur.

USUAL DOSAGE **Adults**—600 mg daily, divided into two or four equally spaced doses. More severe infections: an initial dose of 300 mg followed by 150 mg every six hours or 300 mg every 12 hours. **Gonorrhea** In uncomplicated gonorrhea, when penicillin is contraindicated, Rondomycin[®] (methacycline HCl) may be used for treating both males and females in the following clinical dosage schedule: 900 mg initially, followed by 300 mg q.i.d. for a total of 5.4 grams.

For treatment of syphilis, when penicillin is contraindicated, a total of 18 to 24 grams of Rondomycin[®] (methacycline HCl) in equally divided doses over a period of 10-15 days should be given. Close follow-up, including laboratory tests, is recommended.

Eaton Agent pneumonia: 900 mg daily for six days.

Children—3 to 6 mg/lb/day divided into two to four equally spaced doses.

Therapy should be continued for at least 24-48 hours after symptoms and fever have subsided.

Concomitant therapy: Antacids containing aluminum, calcium or magnesium impair absorption and are contraindicated. Food and some dairy products also interfere. Give drug one hour before or two hours after meals. Pediatric oral dosage forms should not be given with milk formulas and should be given at least one hour prior to feeding.

In patients with renal impairment (see **WARNINGS**), total dosage should be decreased by reducing recommended individual doses or by extending time intervals between doses.

In streptococcal infections, a therapeutic dose should be given for at least 10 days.

SUPPLIED Rondomycin[®] (methacycline HCl) 150 mg and 300 mg capsules, syrup containing 75 mg/5 cc methacycline HCl.

Before prescribing, consult package circular or latest PDR information.

Rev 6/73



WALLACE LABORATORIES
CRANBURY, NEW JERSEY 08512

Leonard Rhyne, who resigned the position to devote full time to his position as associate professor of community medicine (biostatistics), which includes increasing responsibilities in statistical analysis.

Haste comes to Bowman Gray-Baptist Hospital in Lynchburg, Va., where he was manager of engineering and financial marketing systems with the General Electric Company's Communications Systems Business Division.

The computer center, which has a 28-man staff, equipped with a Honeywell 6040 computer. Its application is primarily for business and scientific programs.

* * *

Dr. James C. Leist has been appointed an assistant to the vice president for medical affairs, with primary responsibility for the development of an Area Health Education Center (AHEC) program to serve a 16-county area of northwest North Carolina.

Dr. Leist also will hold a faculty appointment as instructor in community medicine.

For the past two years he has been director of health manpower planning for the Forsyth Health Planning Council in Winston-Salem.

* * *

Dr. David L. Kelly, Jr., associate professor of neurosurgery, was elected vice president of the North

Carolina Neurosurgical Society at the group's organizational meeting in Pinchurst.

* * *

Dr. William S. Pearson, associate professor of psychiatry, has been elected a fellow of the American Psychiatric Association.

* * *

Dr. Harold D. Green, professor of physiology, has been appointed to the Committee on Traffic Safety of the North Carolina Medical Society.

News Notes from the—

UNIVERSITY OF NORTH CAROLINA DIVISION OF HEALTH AFFAIRS

New appointments in the UNC School of Medicine include:

Betsy J. Stover, associate professor, Department of Pharmacology, has been for the past four years an associate professor, part-time, at the University at Chapel Hill and consultant in the Department of Anatomy, University of Utah. She holds the A.B. from the University of Utah and Ph.D. from the University of California.

Joanna S. Dalldorf, assistant professor, Depart-

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ment of Pediatrics, has been affiliated with the Pediatric Supervisory Clinic, District Health Department in Hillsborough since 1968, and the Biological Sciences Research Center at the University at Chapel Hill since 1970. She received her A.B. and M.D. from Cornell University.

Nancy M. Johnson, assistant professor of psychology, Department of Psychiatry, holds the B.A. from Occidental College and the M.A. and Ph.D. from the University at Chapel Hill. She has been a clinical scientist at the University's Biological Sciences Research Center since 1970, lecturer in the School of Education since 1973, and assistant professor, part-time, in the Department of Psychiatry since 1967.

Gerald W. Blake, assistant professor, Department of Medicine, received his B.S. and M.D. from UNC at Chapel Hill. He currently is completing a fellowship in infectious diseases and clinical instructorship at the School of Medicine.

John H. Bryan, assistant professor, Department of Pediatrics, received his undergraduate and medical training at UNC. For the past year he has been a fellow and part-time instructor at the School of Medicine.

Robert G. Dillard, assistant professor, Department of Pediatrics, is completing a two-year tour of duty as a pediatrician at Army Hospital, Ft. Riley, Kan. A graduate of the University of the South, he received his medical training at Yale University School of Medicine and the University of Tennessee.

William F. Finn, assistant professor, Department of Medicine, has been a fellow in nephrology at the UNC School of Medicine for the past two years. He holds the B.S. degree from Le Moyne College and the M.D. degree from S.U.N.Y. College of Medicine, Syracuse.

Neil A. Hoffman, assistant professor, Department of Pathology, is a member of the Medical Corps of the U.S. Army and a pathologist, part-time, for the Alabama State Department of Toxicology and Criminal Investigation. He holds the B.S., M.S., and M.D. from the University of Wisconsin.

David Metz, assistant professor of hospital administration, comes to Chapel Hill from Beth Israel Medical Center where he was assistant director. He also has been a lecturer at Columbia University School of Public Health and Administrative Medicine. A graduate of Queens College of the City University of New York, he received the M.P.A. from New York University.

Felix A. Sarubbi, Jr., assistant professor, Department of Medicine, has been a research and teaching fellow in the UNC Departments of Medicine and Bacteriology since 1972. He received his B.S. from Manhattan College and his M.D. from New York University School of Medicine.

Peter D. Utsinger, assistant professor, Department of Medicine, currently is completing a clinical fellowship in rheumatology at the University of Cali-

fornia at San Diego. He holds the A.B. from Le College de L'Assomption and M.D. from Georgetown School of Medicine.

* * *

Promotions to assistant professor in the UNC School of Medicine include: William H. Bowers, Department of Surgery; Edward W. Davidian and Edward A. Norfleet, Department of Anesthesiology; Alexander B. Filimonov and H. Allen Matthews, Jr., Department of Radiology; Harvey J. Hamrick, Departments of Pediatrics and Family Medicine; Elaine Hilberman, Department of Psychiatry; and David J. Leander, Department of Pharmacology.

* * *

Louis E. Underwood, assistant professor of pediatrics at the UNC School of Medicine, has been selected the Jefferson-Pilot Fellow in Academic Medicine for 1974-1975.

The award, established three years ago by the Jefferson-Pilot Corporation, provides the recipient with \$2,000 per year for four years.

The fellowship program is designed to attract and hold young faculty to the UNC School of Medicine, by enabling them to "explore new ideas, new ways of teaching students, treating patients or investigating biological problems." Selection of each fellow is made by a committee of medical faculty at UNC.

Dr. Underwood, a member of the division of pediatric endocrinology, is interested in the hormonal factors controlling growth. Now he is turning his attention to the study of factors influencing fetal growth.

An understanding of these factors, Dr. Underwood believes, will enable physicians to deal more effectively with disorders resulting from abnormal fetal growth. The research findings also have potentially important implications in the treatment of nutritionally deprived infants, infants of diabetic mothers and premature infants.

* * *

Dr. Timothy N. Taft, senior resident in orthopaedic surgery at North Carolina Memorial Hospital, is the 1974 recipient of the Nathan A. Womack Surgical Society Scholarship.

The society gives the award to the senior surgical resident considered to "best epitomize the qualities of Nathan A. Womack — general excellence in teaching, clinical investigation and patient care." Dr. Womack was the first chairman of the Department of Surgery when the four-year UNC School of Medicine opened.

Dr. Taft will join the School of Medicine teaching staff as an instructor, specializing in sports medicine.

* * *

O'Dell W. Henson, Jr., has been appointed professor in the Departments of Anatomy and Surgery. He is currently an associate professor in the Department of Anatomy at Yale University. He received his

Undergraduate and master's training at the University of Kansas and his Ph.D. at Yale.

Two appointments have been made in the Division of Community Health Service of the UNC School of Public Health at Chapel Hill.

Sherman Brooks, former Fayetteville State University associate professor of health, has been named coordinator of Technical Assistance. Coordinator of Field Relations is Elizabeth Tisdale, former health planner in Charlotte, N. C.

* * *

Other new appointments in the UNC School of Public Health include:

Mildred E. Francis, assistant professor, Department of Biostatistics, holds the B.S. degree from P.C. Teachers College and Sc.M. and Sc.D. from Johns Hopkins University. She has been a statistical consultant for the World Health Organization in New Delhi, India, and for the Food and Drug Directorate, Ottawa, Ontario, Canada.

Peter B. Imrey, assistant professor, Department of Biostatistics, has been a visiting assistant professor at the University here since 1972. A graduate of Columbia University, he received his Ph.D. from UNC.

Alfred W. Rademaker has been appointed assistant professor, Department of Biostatistics, contingent upon completion of his Ph.D. degree from Pennsylvania State University. He holds the B.Sc. and M.Sc. degrees from the University of Manitoba. He has been a research assistant on the "Choice of Model for Reliability Studies" prepared for Aerospace Research Laboratories.

Chirayath M. Suchindran, assistant professor, Department of Biostatistics, has been a visiting assistant professor at the University for the past year. A native of India, he holds the B.Sc. and M.Sc. degrees from the University of Kerala, India, and the M.S.P.H. and Ph.D. degrees from UNC.

* * *

Pranab K. Sen, professor, Department of Biostatistics, will spend a year beginning Aug. 15, 1974, at Iowa State University Department of Statistics. During his leave of absence he also will write a major portion of a research monograph.

* * *

Dr. Dorothy M. Talbot has been named professor and head of the School of Public Health's Department of Public Health Nursing at UNC—Chapel Hill. Formerly director of the Public Health Nursing Section, School of Public Health and Tropical Medicine at Tulane University, Dr. Talbot holds the B.N. degree from Texas Woman's University at Denton; a diploma from Jefferson Medical College School of Nursing, Philadelphia, Pa.; the M.A. degree from Teachers College, Columbia University, N.Y.; and the M.P.H. and Ph.D. degrees from Tulane University.

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Dr. Stephen M. Zeck, graduate dental student at UNC at Chapel Hill, has been awarded a \$7,500 clinical fellowship in pedodontics by the United Cerebral Palsy Research and Educational Foundation, Inc. He will use the one-year award which began Sept. 1 to study the dental problems associated with cerebral palsied children.

* * *

New appointments in the UNC School of Dentistry include:

Richard J. Cray, assistant professor, Department of Periodontics, is completing a year's clinical study at the Indiana University School of Dentistry where he received his M.S.D. A graduate of Michigan State University, he holds the D.M.D. from the New Jersey College of Medicine and Dentistry.

Duane A. Dreyer, assistant professor of oral biology, Department of Oral Surgery and Department of Physiology, School of Medicine, comes to Chapel Hill from Duke University Medical Center where he is a research associate in the Division of Neurosurgery. He holds the B.S. degree from the University of Cincinnati School of Pharmacy and the Ph.D. from the University of Pittsburgh School of Medicine.

Richard D. Jordan, assistant professor, Department of Operative Dentistry, received his B.S. from North Carolina State University and his D.D.S. from the University at Chapel Hill. For the past two years he has been assistant dental officer and division officer of the Naval Dental Corps at Cecil Field, Jacksonville, Fla.

Robert P. Kusy, assistant professor of oral biology, Department of Orthodontics, has been a research associate in the UNC School of Dentistry for the past two years. A graduate of Worcester Polytechnic Institute, he holds the M.S. and Ph.D. from Drexel University.

Charles E. Levy, assistant professor, Department of Periodontics, received his B.A. and D.M.D. from the University of Pennsylvania and a certificate from the Boston University School of Graduate Dentistry.

David E. Kelly, assistant professor, Department of Oral Surgery, has been a teaching assistant in oral surgery at New York University College of Dentistry where he received his D.D.S. degree. He holds the B.A. from Beloit College.

* * *

Promotions in the School of Dentistry include:

To professor: Gerald M. Cathey, Department of Endodontics; Eleanor A. Forbes, Department of Dental Ecology; and Jacob S. Hanker, Department of Oral Surgery.

To assistant professor: Robert B. McCabe, Department of Dental Ecology.

* * *

On leaves of absence in the School of Dentistry are:

James W. Bawden, professor, Department of Pedodontics, is on Kenan leave for a year to conduct

research with Dr. Lars Hammarstrom, participate in teaching of pedodontics and observe the Swedish dental system. He also will consult on curriculum revision at the University of Lund, Malmo, Sweden.

John M. Gregg, associate professor, Department of Oral Surgery, will work with the University of Washington School of Medicine Pain Control Clinic and study research projects while on leave from Aug. 1, 1974 to Jan. 31, 1975.

Dr. Seymour M. Blaug of the University of Iowa was appointed dean of the School of Pharmacy and professor of pharmacy at UNC-Chapel Hill effective August 15.

Dr. Blaug succeeds Dr. George P. Hager, who will return to teaching and research after eight years in the administrative role.

Dr. Blaug joined the University of Iowa faculty in 1955 and has been a Professor of Pharmaceutics there since 1962. A native of New York City, Dr. Blaug earned the B.S. and M.S. Degrees from Columbia University College of Pharmacy and the Ph.D. degree from the University of Iowa.

* * *

Congressman L. H. Fountain announced that the School of Pharmacy at UNC at Chapel Hill has received a \$386,228 federal grant for the 1974-1975 school year.

The grants represent a slight increase over the previous capitation grants.

The grant is based on the number of enrolled students and is in support of the school's activities—curriculum improvements, training of pharmacy students for new roles and levels of service and clinical pharmacy and drug education programs.

The University of North Carolina at Chapel Hill has received \$315,000 in grants to support allied health programs in the Medical and Dental Schools.

Dr. Ralph H. Boatman said the grants would be used to strengthen and expand allied health programs in physical therapy and radiologic technology and to provide trainee support in physical therapy and the dental auxiliary teacher education program.

Boatman is director of the Office of Allied Health Sciences at UNC.

Physical therapy in the Medical School gets \$187,500. Another \$98,600 goes to radiologic technology, also in the Medical School. Dental auxiliary in the Dental School, receives \$29,000.

Pat Lawrence of the UNC School of Nursing at Chapel Hill has been elected to the Board of Directors of the American Diabetes Association.

Miss Lawrence, assistant professor in the Continuing Education Program, has been a member of the Board of Directors of the N. C. Diabetes Association and educational director of the Diabetes Project of the N. C. Regional Medical Program.

Promotions to new assistant professors in the School of Nursing include: Jane M. Hayward, Jane M. Parfitt and Sandra L. Venegoni.

The U. S. Senate was urged June 20 to create an advisory commission on nutrition because of the world food crisis.

Dr. Howard A. Schneider, reading a report prepared by the American Institute of Nutrition (AIN), told the Senate's Select Committee on Nutrition and Human Needs "a new governmental apparatus must be set in place to provide for the emerging role of the United States as the foremost world food exporter."

Schneider, director of the University of North Carolina Institute of Nutrition, is cochairman of the AIN's panel on "Nutrition and the Consumer" and chairman of the subpanel "Popular Nutrition Education," which prepared the report.

The AIN panel also recommended the passage of a national nutrition education act.

North Carolina has some 300,000 persons whose drinking has caused problems for them, their families, their friends, employees or the police, Dr. John A. Ewing told members of the N. C. Association of ABC Boards' meeting in Myrtle Beach, S. C., July 15.

Calling for the support of the N. C. Alcoholism Research Authority, Dr. Ewing urged that North Carolinians invest their dollars in alcohol research in addition to spending millions on rehabilitation.

Dr. Ewing is director of the University of North Carolina Center for Alcohol Studies in Chapel Hill.

Nobody knows what alcoholism costs in North Carolina, he said. State treatment programs alone run well over \$10 million.



ac /, program and environment
the individual to maintain
ain respect and recover with



I examination upon admis-



, motel-like accommodations
private bath and individual
nature control.



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DUKE UNIVERSITY MEDICAL CENTER

Dr. Ewald W. Busse, chairman of the Department of Psychiatry at Duke University, became Duke's Director of Medical and Allied Health Education on Sept. 1.

He succeeds Dr. Thomas D. Kinney, who has been director since 1969 and who is retiring from administrative responsibilities to return to teaching and research.

Kinney also is chairman of the Department of Pathology, a post he has held since coming to Duke in 1960. He will continue to administer that department until a successor arrives within the next few months.

Unlike most medical schools, Duke does not have a dean of the School of Medicine. Instead, the Director of Medical and Allied Health Education is the chief educational officer of the medical center. He functions as a medical dean and also is responsible for graduate and continuing medical education, as well as education in the multiple fields of allied health training under way at Duke. The School of Nursing is administered separately by a dean.

In structuring medical and allied health education in that manner, the Duke administration felt it provided a more completed overall coordination of educational functions at the medical center.

In addition to the director, there are associate directors reporting to him who are responsible for undergraduate medical education, admissions, allied health, continuing education and graduate medical education.

"The university and its medical center are deeply grateful for Dr. Kinney's strong and effective leadership in medical and allied health education during the past five years," said Dr. William G. Anlyan, vice president for health affairs.

"Under his stewardship, the evolutionary major changes in the medical curriculum at Duke have been firmly established and improved substantially. Dr. Kinney has also established a formal Division of Allied Health with high quality programs. We are certain that Dr. Busse will continue the tradition of excellence in medical and allied health education as well as to provide his own intellectual leadership to the future directions of development," Anlyan said.

Kinney, who is recognized as one of the country's leading medical educators, is the only person to have held the medical-allied health directorship at Duke.

He is chairman of the Liaison Committee on Medical Education of the Association of American Medical Colleges (AAMC) and the American Medical

Association (AMA), and he also was president of the AAMC's Council of Academic Societies.

In 1972-1973 Kinney was president of the Federation of American Societies for Experimental Biology and he has served as chairman or president of a number of other professional organizations including the Association of Pathology Chairmen.

Kinney currently is editor of the *American Journal of Pathology*.

A native of Pennsylvania and a graduate of the University of Pennsylvania with an A.B. in 1933, Kinney received his M.D. at Duke in 1936. Following internship and residency, he held teaching appointments at the Tufts College of Medicine and Yale, Boston and Harvard universities from 1937 to 1947.

In 1947 he began a 13-year association with what is now Case Western Reserve University in Cleveland, leaving there in 1960 to chair the Department of Pathology at Duke.

Since 1967 Kinney has been R. J. Reynolds Professor of Medical Education.

The new director, Busse, who will retain his appointment as J. P. Gibbons Professor of Psychiatry, has received national recognition for his work in psychiatry and gerontology. He was president of the American Psychiatric Association (APA) in 1970-1972.

He holds a Certificate of Commendation from the APA and a Citation of Merit from the Gerontological Society, of which he also was president.

It was Busse who established Duke's Center for the Study of Aging and Human Development in 1957, four years after coming to Duke to chair the Department of Psychiatry. He headed the center until 1970.

Busse has held numerous research awards, consultant appointments to federal agencies and has served as a member or officer of more than 30 professional organizations and as editorial advisory board member of eight professional publications.

Busse is a native of Missouri where he received an A.B. degree in 1938 at Westminster College, Fulton. The college awarded him an honorary doctorate in 1960. He received his M.D. degree at Washington University in St. Louis in 1942.

Following postgraduate training and military service, Busse joined the faculty of the University of Colorado School of Medicine where he advanced from instructor to full professor between 1946 and 1953, the year he accepted the psychiatry chairmanship at Duke.

* * *

Dr. H. Keith H. Brodie of Stanford University is the chairman of the Department of Psychiatry.

Brodie, who is an assistant professor of psychiatry at Stanford, will succeed Dr. Ewald W. Busse who is assuming the position of Director of Medical

lled Health Education. Brodie's Duke rank will be full professor.

In addition to his teaching duties at Stanford, Brodie has been program director of the medical school's General Clinical Research Center.

Brodie earned an A.B. degree in chemistry at Princeton in 1961 and was awarded an M.D. degree at Columbia in 1965.

He served an internship at Ochsner Foundation Hospital in New Orleans, followed by a residency in psychiatry at Columbia-Presbyterian Medical Center in New York. He was a clinical associate in the Section on Psychiatry, Laboratory of Clinical Science, of the National Institute of Mental Health for two years prior to joining the Stanford faculty in 1970.

Brodie is a member of the editorial board of "Psychiatry Digest" and he is associate editor of the *American Journal of Psychiatry*.

He is a member of numerous professional organizations and currently is chairman of the program committee of the American Psychiatric Association. He also has served as a consultant to the federal government on narcotics and drug abuse, and in 1972 he was a visiting lecturer at Duke for a symposium on drugs and the aging patient.

Among administrative and departmental responsibilities at Stanford, Brodie has been special assistant to the chairman of psychiatry for administration, a

member of the department's administrative and budget committees, premedical advisor and chairman of the Medical School Faculty Senate.

MEDICAL DIRECT MAIL DECLINES

According to the Pharmaceutical Manufacturers Association (PMA), the typical busy physician receives an average of four pieces of medical mail per day. "This represents a 38 percent decline since 1959," C. Joseph Stetler, PMA president, said, "and negates any claim that such mail is proliferating. Actually, through the use of the computer and other techniques, medical mail today is much more selective and efficient; the circulation of an average mailing dropped to less than 20,000 in 1973 compared to an average of 55,000 in 1959."

Sharply increasing costs for paper, printing, copywriting, design, royalties, and handling charges have also contributed to a decline in the volume of direct mail.

Medical direct mail serves a number of valuable goals including speed in transmitting information about drug therapy, providing more detailed information than may be possible in other ways, and enhancement of the dialogue between physician and manufacturer.

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rural areas where detail men are seen irregularly, if at all," Stetler said.

A NEW BOOKLET FOR THE NEW OSTOMATE

A brochure prepared to aid the new ostomate return to a full and normal life is being made available without charge, as a professional service by E. R. Squibb & Sons, Inc., to surgeons, family physicians, nurses and enterostomal therapists.

The booklet, "An Ostomy is for Living," is de-

signed to reassure the new ostomate that there are only a few limitations to the return to a routine life-style.

It answers many of the commonly asked questions of the new ostomate concerning showering and bathing, clothing, diet, exercise and sports, and traveling. The booklet discusses problems that might be encountered with adhesives and appliances, and ways to handle or avoid them.

Copies of the brochure may be obtained by writing Hospital Division, E. R. Squibb & Sons, Inc., P. O. Box 4000, Princeton, N. J. 08540.

Month in Washington

Chances of passage this year of any national health insurance (NHI) proposal seem to be dwindling away. The indefinite postponement of Senate Finance Committee hearings on NHI and termination of the House Ways and Means Committee's once-a-week hearings seem to indicate that Congress feels it has more pressing matters to deal with, or is baffled as to how to proceed with mandating health insurance for all.

Some veteran Capitol Hill observers believe the most important factor in congressional dawdling on the NHI issue is genuine bafflement — which has led to sharp controversy — on how such a program should be financed.

Most of the NHI proposals vary only slightly in the scope of benefits, and there is no sharp disagreement that the program should be comprehensive in nature. All but one or two of the proposals agree that the administration of the program should be derived from a combination of the federal and private sectors, using the existing private health insurance industry, controlled by federal guidelines and regulations.

The problem is how the program should be financed. Should the program be financed by a Social Security payroll tax, by mandated employer-employee financing, or by a tax credit system, such as proposed by the American Medical Association in its Mediredit plan?

It is in the area of financing that conservatives find the dangers of NHI. When a program is financed directly through federal revenues, it is an open invitation for government to use those dollars as a lever to manipulate the entire program — "an inappropri-

ate intervention of the federal government into private affairs and responsibilities."

Each of the proposed methods for financing an NHI program has powerful allies in both the Congress and in the private sector. It would seem that this Mexican standoff is a major reason for this Congress' delay. Short of an unlikely compromise brought on by a complete about-face by one of the major contending forces, it appears that the 93rd Congress will not legislate a national health insurance program.

Another reason for congressional foot-dragging on NHI is that time is running out for the 93rd Congress and its "must" work is still piled high. For example, still to surface from the powerful House Ways and Means Committee is its promised tax reform measure, the long ago announced top priority of the Committee.

* * *

The House's Interstate and Foreign Commerce subcommittee on health has crushed, by an eight to one vote, a public utility-like plan that would control physician fees and hospital charges—a provision regarded by many as the most threatening health measure on Capitol Hill.

The vote appeared to assure the doom of the public utility concept both in the full House Commerce Committee and the House. There remains the possibility of Senate approval, however.

The controversial provision is part of a comprehensive and complicated rewriting of the Comprehensive Health Planning and Regional Medical Programs of the federal government. The proposed strict rate controls exercised by the states are backed by

Sen. Edward Kennedy (D-Mass.) and Rep. William Byrd (D-Kans.), the latter a physician who cast the tie vote for the provision in the House subcommittee.

Opponents of the plan were subcommittee Chairman Paul Rogers (D-Fla.) and Democratic Reps. David Satterfield (Va.), Peter Kyros (Maine), Richardson Preyer (N.C.); and GOP Reps. Anner Nelson (Minn.), Tim Lee Carter (Ky.), James Eastland (N.Y.), and H. John Heinz, III (Pa.). Present, but favoring the majority position, were Reps. William Hudnut (Ind.) and James Symington (Mo.).

The vote was on a motion to strike from the bill language that would have authorized federal funding for State Health Commission programs of regulating charges in the medical field with ultimate authority in the HEW Department.

Health providers have opposed the plan. Declaring that the legislation has "far reaching implications for the future delivery of health care services," Richard Palmer, M.D., Chairman of the American Medical Association's Board of Trustees, told the subcommittee earlier this year that under the disputed plan the health sector in effect would be deemed to be a vast, monolithic public utility."

Dr. Palmer said, "We must caution against the imposition of a massive bureaucratic control of the health care system . . . the economic forces inherent

in this proposal could defeat the intention of this Committee to foster the development of improvements in our health care delivery system."

The subcommittee adopted a requirement that the local planning agencies monitor individual institutional rates within the state and publicly comment on such rates.

Also included in the subcommittee draft are provisions to require states to have certificate of need legislation, or similar legislation relating to the construction of new facilities.

States would be required within three years to review and comment on the need for all facilities and services provided within the state.

* * *

A slashing attack against the nation's reliance upon foreign medical graduates (FMGs) has been launched in Washington by the Association of American Medical Colleges (AAMC).

The present situation "undermines the process of quality medical education in this country and ultimately poses a threat to the quality of care delivered to the people," according to a report by an AAMC task force on FMGs headed by Kenneth Crispell, M.D., vice president for health affairs at the University of Virginia.

Endorsed by the AAMC executive council, the blunt assault on the immigration of FMGs called for

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sicians. Said the AMA: "Licensure per se cannot assure high quality of medical care or effectiveness of the practice of physicians. Relicensure has the same limitations. Under present circumstances, the

process of relicensure could severely disrupt the care of patients in many instances because physicians would have to prepare for examinations and be away from patient care while taking them."

Book Reviews

Arthritis. Complete, Up-to-Date Facts for Patients and Their Families. By Sheldon Paul Blau, M.D., and Dodi Schultz. Price, \$4.95. Garden City, New York: Doubleday & Company, Inc., 1974.

This book has some interesting factual information. The latter chapters on diet, home care and sex should provide useful information for arthritics and their families.

However, most chapters seem too medically detailed for the "average patient" and can therefore easily lead to the patient's confusion. For example, the discussion concerning phalangeal osteoarthritis (page 68) emphasizes the absence of a history of repeated stress or trauma, but the discussion concerning the etiology of osteoarthritis (page 69) emphasizes these factors in the pathogenesis of this disease.

Repeated statements are made condemning self-diagnosis, but the middle chapters detailing the various types of rheumatic diseases are written in such a way as to perhaps encourage this practice in the unwary reader. The discussions on treatment seem to emphasize too strongly the side effects, and too weakly the anticipated therapeutic successes of present-day therapeutic regimens for arthritis.

The book should be useful reading for interested health professionals and previously well informed arthritis patients and their families.

BARBARA H. MUSE, *Medical Assistant*
ROBERT A. TURNER, M.D.

The Ultimate Stranger. By Carl H. Delacato. Ed.D., 226 pages. Price, \$6.95. Garden City, New York: Doubleday & Company, Inc., 1974.

This is a book that will, in all likelihood, appeal to those who accept the concepts and the diagnostic and therapeutic approaches of the Institutes for the Achievement of Human Potential (IAHP). It will not appeal to those who do not agree with the IAHP approach. The writing is not scientific, although the scientific bibliography is relatively extensive. There is much first person emphasis and bias and a tendency toward overly enthusiastic statements.

It is to be admitted that the therapy of the many types of children who are categorized as autistic has

been relatively unproductive. The number of cases the author cites in this volume is insufficient to allow any judgment, pro or con his approach, which is only one of several "new" approaches being tried with autistic children.

The book will undoubtedly raise the hopes of many parents. It would have been more appropriate, perhaps, to have treated a reasonable number of children and published a scientific paper comparing results to other series, before writing a book for parents and nonprofessionals, extolling the virtues of an, as yet, inadequately tested therapeutic approach.

ALANSON HINMAN, M.D.

Handbook of Microbiology, Vol. I, Organismic Microbiology. Allen I. Laskin and Hubert A. Lechevalier (eds.). 940 pages. Price, \$36.00. Cleveland, Ohio: CRC Press, 1973.

This book is the first in a series of four volumes. Subsequent volumes will be entitled *Microbial Composition* (Vol. II), *Microbial Products* (Vol. III), and *Microbial Metabolism, Genetics and Immunity* (Vol. IV). As the title suggests, this publication is a handbook of microbiology, rather than a textbook, and is primarily intended for reference purposes. The authors have been brief and utilized charts and tables whenever possible, as the editors instructed.

Volume I is divided into seven sections entitled Bacteria, Fungi, Algae, Protozoa, Viruses, Methodology, and General Reference Data. The first section on Bacteria (260 pages) is devoted primarily to brief descriptions of *Chlamydia*, *Rickettsia*, and the ten orders of *Bacteria*. The chapters vary from broad descriptions and generalities to the inclusion of micrographs and drawings illustrating various organelles and appendages. Approximately 35 pages deal with bacteria of clinical significance. The chapter describing the family Enterobacteriaceae is lacking in many respects and tends to confuse, rather than to simplify, the subject matter.

The next 179 pages describe the four familiar, although older, classes of fungi: Phycomycetes, Ascomycetes, Basidiomycetes, Deuteromycetes. Taxonomic keys and some physiological characteristics are pri-

arily presented. A short chapter on lichens (six pages) concludes this section.

The 34 pages comprising the section on algae are primarily a listing of pertinent references with a brief paragraph describing each phylum.

The section on protozoa is even shorter (27 pages) than those previously mentioned and is predominantly taxonomic.

The section on viruses (142 pages) is subdivided into plant, invertebrate and vertebrate viruses, and bacteriophages. The chapters on plant and invertebrate viruses perhaps are among the few that are presented in the manner of a handbook—a listing of various viral entities and a few well chosen generalities concerning each group. The chapter on vertebrate viruses is somewhat longer but tends to lose the reader in the vast complexity of taxonomic and biochemical tables. The major chapter in this section deals with bacteriophages. There are 77 pages of tables, charts and figures describing, in a rather neat and concise form, virtually every known characteristic of various phages.

The last two sections, Methodology and General

Reference Data (258 pages) include information most microbiologists would expect to find in a handbook of this type, i.e., sterilization techniques, microscopy, staining methodology, safety rules and postal regulations, international associations of microbiology, literature guides, procedures for preserving microorganisms, colleges and universities offering degrees in microbiology, and the like.

It is difficult to determine to what practical end anyone would seek out this book. Microbiology does not readily lend itself to the strict regimentation seen in this type of publication. Most areas considered in this handbook, except Methodology, General Reference data, and some aspects of Virology, are not the subjects that one would refer to in a handbook, especially since specific texts are available.

As with most handbooks, this one was intended to be used as a quick reference. However, a four volume set could hardly be considered a handbook, and the price of this handbook most likely will relegate it to the shelves of university libraries.

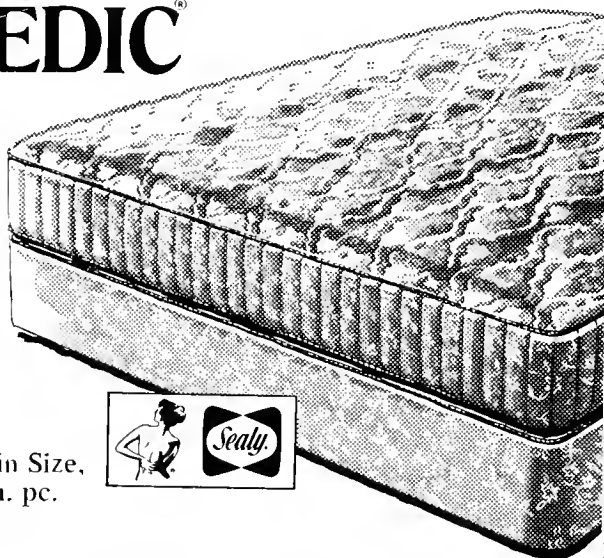
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M. J. Hornowski, M.D.

Dr. M. J. (Jerry) Hornowski died on January 8, 1974, at the age of 53, after a long illness. He had practiced psychiatry in Asheville since 1951.

A native of Brooklyn, New York, he attended the University of Virginia where he received both his A.B. and M.D. degrees. He was a member of the University of Virginia basketball and baseball teams from 1937 to 1940. He interned at King County Hospital, served two years in the U.S. Navy Medical Corps and had his specialty training at the Menninger Clinic.

Dr. Hornowski was a staff member of Memorial Mission Hospital, St. Joseph's Hospital and a member of the Buncombe County Medical Society, North Carolina State Medical Society, American Medical Association, American Psychiatric Association, Southern Psychiatric Association and North Carolina Psychiatric Society. He was a past president of the Academy of Religion and Mental Health and former president of the Mental Health Center of W.N.C.

Perceptive and articulate, Jerry was frequently in demand as a speaker to professional and lay groups. He maintained a vital interest in man and his community. His empathy and skill made him an exceptionally effective practitioner. He was accorded great respect, and will be painfully missed by all who knew him.

He is survived by his widow, Mrs. Grace Young Hornowski, his mother, three children and three sisters.

BUNCOMBE COUNTY MEDICAL SOCIETY

Leonard Palumbo, M.D.

Dr. Leonard Palumbo died at North Carolina Memorial Hospital in Chapel Hill, April 21, 1974, after a short illness. He was born May 18, 1921, in New York City.

Dr. Palumbo received his undergraduate education

at Duke University. He earned his M.D. degree from Duke University School of Medicine in 1944 under an accelerated training program. From 1944 to 1950 he served a residency in obstetrics and gynecology at Duke Medical Center.

From 1950 to 1952 Dr. Palumbo was an associate in obstetrics and gynecology at Duke Medical Center. In November 1952 he joined the obstetrics and gynecology faculty at the University of North Carolina School of Medicine as assistant professor. From 1956 to 1964 he was associate professor. He was appointed professor of obstetrics and gynecology in 1964.

He was a member of many professional organizations and scholastic honorary societies including Phi Beta Kappa, Alpha Omega Alpha, Sigma Xi, Diplomate American Board of Obstetrics and Gynecology, American Medical Association, North Carolina State Medical Society, American College of Obstetrics and Gynecology, North Carolina Obstetrical Society, and the Southern Medical Association. He was a founding member and past-president of the Southeastern Society of Obstetrics and Gynecology and past president of the South Atlantic Society of Obstetrics and Gynecology. He was a member of the Robert A. Ross and Bayard Carter Obstetrical and Gynecology Societies.

Dr. Palumbo was the author of numerous papers in his field. His special interest was cancer of the female reproductive system.

He was one of the original members of the Obstetrics and Gynecology Department, North Carolina Memorial Hospital. He was a dedicated physician who was loved by his patients and highly respected by his colleagues and students alike.

He is survived by his parents, Mr. and Mrs. Leonard Palumbo, and one brother, Edward Arthur Palumbo.

MCPHERSON HOSPITAL STAFF

NORTH CAROLINA

Medical Journal

IN THIS ISSUE: Pseudocholinesterase Abnormalities as a Cause of Postanesthetic Apnea, Francis M. James, M.D.; Family Practice: One Answer, Lyndon K. Jordan, M.D.; Survey of Health Education in the North Carolina Public Schools, Martha Y. Martinat.

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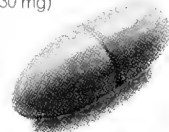
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Pseudocholinesterase Abnormalities as a Cause of Postanesthetic Apnea

Francis M. James, M.D.

SUCCINYLCHOLINE, a potent, depolarizing muscle relaxant, is often given before, or during, an operation. Normally, the body provides an enzyme, pseudocholinesterase, which rapidly metabolizes succinylcholine. However, for at least 16 years it has been known that abnormal forms of pseudocholinesterase exist in some patients, that these persons are unable to destroy succinylcholine *in vivo*, and that these abnormalities are genetically linked and appear in families. Decreased amounts of pseudocholinesterase exist in some patients, and these small amounts take an abnormally long time to break down succinylcholine. Three cases of abnormal succinylcholine metabolism with the relevant family genetic patterns that have been seen in western North Carolina hospitals within the past 16 years are presented.

CASE REPORTS

Case 1

A single, white, 17-year-old primigravida was admitted to the hospital, at eight weeks' gestation, for therapeutic abortion for psychiatric reasons. She had had infectious

hepatitis two years earlier. No problems had arisen when she was anesthetized for a tonsillectomy as a child. She had no history of drug idiosyncrasy, and she was taking no medications. The patient weighed 135 pounds and was 69 inches tall.

Diazepam, 10 mg, and atropine, 0.4 mg, were administered one hour before the operation began. Anesthesia was induced and supplemented with an intravenous injection of thiopental, total dose of 500 mg, and maintained with nitrous oxide, 5 L/min, and oxygen, 2/L min, via a face mask. Immediately before and during cervical dilation, 0.1 percent succinylcholine was administered via an intravenous drip, a total of 50 mg being given over a five minute period. Muscle fasciculations occurred and all spontaneous respiration ceased. Positive pressure ventilation by mask was started, and a paracervical block with 30 ml of one percent lidocaine was used to facilitate cervical dilation. The procedure was completed in less than ten minutes.

Anesthesia was discontinued after a total of 15 minutes, but the patient remained apneic. Her pupils were dilated equally and reacted briskly to light. Soon thereafter a nerve stimulator (Burroughs-Wellcome "Block-aid" Monitor) was ap-

plied near the ulnar nerve at the elbow and wrist, but no muscle activity could be seen. A tentative diagnosis of atypical pseudocholinesterase was made.

Intermittent positive pressure ventilation was maintained with oxygen via a mask. The patient's blood pressure remained stable at 130/80 mmHg and her pulse ranged from 90 to 120 beats per minute. One hour and 15 minutes after the succinylcholine drip was discontinued, she began to make gross movements, primarily with her legs. Five minutes later, the patient began jerky diaphragmatic breathing. Nerve stimulation with the Block-aid Monitor produced a weak muscle twitch, fade during tetanic stimulation and post-tetanic facilitation. She improved gradually, and three hours after the succinylcholine administration she no longer needed ventilatory assistance. One hour later the patient was quite strong and could lift her head off the bed. No residual myoneural block was demonstrated with the Block-aid Monitor.

Case 2

This gravida 5, para 4, 33-year-old white woman was admitted, when 17 weeks pregnant, for a hysterotomy and tubal ligation for toxemia of pregnancy. Her blood pres-

From the Department of Anesthesia, The Bowman Gray School of Medicine of Wake Forest University, Winston-Salem, North Carolina

sure on admission was 136/84 mmHg, and her pulse rate was 104 beats per minute. She weighed 125 pounds. The patient had had hypertension during her first pregnancy, and again during this fifth pregnancy (180-190, 100-110 mmHg). After two previous pregnancies she had problems with postpartum hemorrhage. Renal problems of an unknown type occurred during her second pregnancy. When her appendix had been removed 10 years previously she had no difficulty when given a general anesthetic. The patient had no history of drug sensitivity. She was taking diazepam as needed for nervousness, and hydrochlorothiazide to decrease her blood pressure. Her serum potassium level was 3.3 mEq/L; results of other preoperative laboratory studies were normal.

Meperidine, 75 mg, and atropine, 0.6 mg, were given intramuscularly one hour before the operation. An intravenous infusion of potassium chloride in dextrose and water had been started three hours earlier. Anesthesia was initiated with thiopental, 250 mg, and maintained with nitrous oxide-oxygen and methoxyflurane. Succinylcholine, 20 mg, was given to facilitate tracheal intubation. The patient stopped all spontaneous breathing for the next hour and 15 minutes. She then was sustained on assisted ventilation.

The operation was completed 25 minutes later and anesthesia was stopped. At that time she was awake and moving, her respirations appeared to be adequate, and the endotracheal tube was removed. Soon afterward, she became cyanotic and less mentally alert. Her blood pressure rose to 260/120 mmHg, and her heart rate increased to 118 beats per minute. Approximately two and one-half hours after the initial induction of anesthesia, the endotracheal tube was reinserted and connected to a Bird ventilator. Within an hour her blood pressure decreased to 130/80 mmHg, and she was alert. Four hours after succinylcholine was given, the endotracheal tube was removed a second time, but respirations failed quickly and she again became somnolent. The endotra-

cheal tube was reinserted and respiration was again assisted with a ventilator. Approximately five hours after the succinylcholine was administered the patient was able to raise her head from the bed, had a strong grip, and could breathe without assistance. The endotracheal tube was again removed. The remainder of her hospital stay was uneventful.

Case 3

A 24-year-old white man was admitted to the hospital for repair of an indirect, inguinal hernia on the left side. His health was generally good, he had had no previous operations, and he was taking no medications. Results of laboratory tests were normal. The patient weighed 182 pounds and was sixty-eight and three-fourths inches tall.

He was given meperidine as premedication. Anesthesia was induced with 250 mg of thiopental and maintained with nitrous oxide-oxygen and halothane. The patient was given 20 mg of succinylcholine, intravenously administered, to aid tracheal intubation. Very little anesthetic agent was needed to keep him relaxed and asleep. At the end of the operation, he failed to breathe spontaneously, and controlled ventilation with oxygen via the endotracheal tube was continued. Caffeine-sodium benzoate was given, but it did not arouse the patient; two 5 mg doses of nalorphine did not produce significant respiratory improvement. Three hours and 20 minutes after the operation was completed, the patient was alert, could lift his head voluntarily, and had a good hand grip. The endotracheal tube was removed and he breathed well.

DISCUSSION

There are many reasons that patients fail to breathe after being given a general anesthetic. Premedication, narcotics included in premedication or used to augment light anesthesia, persistent effects of general anesthetic agents, hypocarbia secondary to hyperventilation, hypercarbia in excess of arterial levels of 100 Torr, residual effects of muscle relaxants, brain damage from hypoxia or direct trauma, hypothermia, and

respiratory obstruction must be considered.

In the foregoing three cases, measurement of arterial blood gases would have been useful in providing acid-base status and levels of oxygen and carbon dioxide. The narcotic meperidine was given as premedication to the patients in case 2 and 3, but the narcotic antagonist nalorphine, given in adequate doses, failed to improve the patient's respiration in case 3. Hypothermia did not occur in the patients in cases 2 and 3; temperature was not monitored in the patient in case 3. In all three patients, the general anesthetic agents were discontinued several hours before adequate respiration returned. Light levels of anesthesia were maintained during the operations, and in each case the duration of respiratory depression was out of proportion to the amount of anesthesia administered. In case 2, the patient was alert at the end of the operation but became somnolent when her respiration failed. The periods of hypertension, tachycardia and somnolence in this patient most likely represented periods of hypercarbia, whereas the cyanosis of the head and neck resulted from hypoxia. Fortunately, the hypoxia was corrected promptly by controlled ventilation each time it occurred. There was no reason to suspect hypoxic brain damage in any of the three patients. Considering all factors, we believe that residual effects of the muscle relaxant, succinylcholine, were responsible for inadequate respiration in these three patients.

The prolonged effect of a muscle relaxant may be caused by overdosage, inadequate reversal, acid-base imbalance, interaction with certain antibiotics (e.g., streptomycin, neomycin and kanamycin), electrolyte imbalance, and in the case of succinylcholine, abnormal or insufficient amounts of pseudocholinesterase. The largest dose of succinylcholine given to these three patients was 5 mg, given in case 1. Very small amounts (20 mg) were given to the other two patients. None of the patients was taking antibiotics. On case 2 might an electrolyte im-

...ance have been suspected. That patient had been given potassium chloride intravenously for three hours before the operation. She had a nearly postoperative serum potassium level of 4.3 mEq/L. Again, measurement of blood gases would have been helpful in determining acid-base status, but the measurement was not made in any of these cases.

The level of pseudocholinesterase in the blood may be reduced by severe liver damage, disease or malnutrition (since the liver produces pseudocholinesterase), and the late stages of pregnancy. The patient in case 1 had no known residual effects of the hepatitis occurring two years previously. The prolongation of a 5 mg dose of succinylcholine in a patient with hepatic failure is unimpressive, rarely being longer than 20 minutes.¹ For these reasons we felt that liver damage was not a factor in the reduced level of pseudocholinesterase in these patients. None of the patients was taking drugs that are known to alter the level of pseudocholinesterase in the blood.^{2, 3} Vix and Orkin's⁴ study of healthy electric patients showed that pseudocholinesterase is reduced by 28 percent during late pregnancy, 16 percent during labor, 25 percent one week postpartum, and 32 percent three days postpartum, although qualitatively the enzyme remains normal. The patients in cases 1 and 2 were pregnant, but neither was past the early portion of the midtrimester, so pregnancy-induced prolongation of apnea should not have been a factor.

Normally, *in vivo*, 40 to 60 mg of succinylcholine is destroyed by pseudocholinesterase within two to three minutes; a period of succinylcholine-induced apnea that lasts for more than ten minutes, therefore, is abnormal. For this reason, abnormal or decreased amounts of pseudocholinesterase in these three patients was suspected. Abnormal amounts of pseudocholinesterase were subsequently confirmed by laboratory tests.

At least four genes exist for the production of pseudocholinesterase:

Table 1
*Information on Pseudocholinesterase Genes⁵

Genotype	Incidence	Response to Succinylcholine	Average Dibucaine Number	Average Fluoride Number
N-N	96%	Normal	80	60
D-D	1:2,500	Prolonged ++	20	20
S-S	1:100,000	Prolonged +++	0	0
F-F	Rare	Prolonged +	70	30
N-D	1:25	Prolonged	60	45
N-F	?	Prolonged	75	50
N-S	1:200	Prolonged	80	60
D-F	?	Prolonged +	45	35
D-S	1:800	Prolonged ++	20	20
F-S†	?	Prolonged	70	20

† Not yet observed

N = normal pseudocholinesterase gene

D = dibucaine resistant variant

F = fluoride resistant variant

S = silent gene

* Reproduced with permission from Pantuck EJ: Genetic aspect of neuromuscular blockade, in Mark LC, Pappas EM (eds): *Advances in Anesthesiology: Muscle Relaxants*. New York: Harper and Row, 1967, p 63.

normal, dibucaine resistant (atypical), fluoride resistant and silent. These genes can combine to produce ten different genotypes, six of which cause greatly increased sensitivity to succinylcholine (Table 1).⁵ Kalow⁶ has estimated that one of these six genotypes occurs in every 1,500 patients. The two types of pseudocholinesterase first identified were termed normal (N) and atypical (D).⁷ The only difference between them is one of degree—both can hydrolyze succinylcholine *in vitro*, but only the normal succeeds clinically in instances of low concentration of succinylcholine. When succinylcholine is given to a patient, the concentration in the blood is lowered rapidly by dilution in the blood stream. The relaxant's concentration thus falls below the effective level for hydrolyzation by atypical pseudocholinesterase.

Atypical pseudocholinesterase is termed dibucaine-resistant, because dibucaine is used to determine its existence. Benzoylcholine is a specific substrate of pseudocholinesterase that is not hydrolyzed by true cholinesterase. A 10⁻⁵ molar concentration of dibucaine hydrochloride under standard conditions inhibits benzoylcholine hydrolysis by atypical pseudocholinesterase by 20 percent or less. This same concentration of dibucaine hydrochloride inhibits hydrolysis of benzoylcholine by normal pseudocholinesterase by 70 percent or more.⁸ The dibucaine

number on Table 1 is the percent of inhibition of benzoylcholine hydrolysis caused by dibucaine. In patients who are homozygous for atypical pseudocholinesterase, 100 mg of succinylcholine will produce approximately one hour of apnea.⁸ Even after respiratory effort returns, it is often inadequate, and respiration must be assisted for an additional two to three hours.

In 1961, Harris and Whittaker⁹ noted that sodium fluoride could be used in place of dibucaine, and that it revealed a fluoride-resistant (F) variant of pseudocholinesterase. The following year, Liddell and colleagues¹⁰ found a fourth gene, the silent gene (S), while using the dibucaine test. Patients with the silent gene have no pseudocholinesterase activity and, therefore, have a very prolonged response to succinylcholine.

Figures 1 and 2 show family genotypes for all three cases. Cases 1 and 3 represent DD genotypes, and case 2 represents a heterozygous DF genotype. These are two of the genotypes which prolong the effects of succinylcholine. Even though the genotype was abnormal, the four hours' prolongation of the effect of succinylcholine was remarkable in cases 2 and 3, when one considers the small amount of succinylcholine given (20 mg).

The diagnosis of abnormal pseudocholinesterase is made in the laboratory. In addition to the dibucaine

and fluoride testing, there is measurement of the cholinesterase rate which determines in units the amount of normal pseudocholinesterase present. The normal range is 80 to 120 units.

Suspected abnormal pseudocholinesterase activity can be confirmed during anesthesia with a peripheral nerve stimulator, as demonstrated in case 1. The nerve stimulator depo-

larizes a peripheral nerve, causing myoneural transmission and muscle contraction. Although the pattern of response to the nerve stimulator helps one assess myoneural transmission, it does not allow one to distinguish between abnormal forms of pseudocholinesterase and low levels of normal pseudocholinesterase.

When a patient fails to breathe adequately at the end of anesthesia,

ventilation must be supported to ensure adequate oxygenation and carbon dioxide removal. One hundred percent oxygen can be used initially. If residual effects of succinylcholine are the cause of inadequate breathing, the patient will recover uneventfully in several hours, since metabolic pathways other than pseudocholinesterase hydrolysis, primarily alkaline hydrolysis, will ultimately destroy succinylcholine. Until it is clear, however, that the patient is breathing well and will continue to breathe well, he must be watched by anesthesia personnel.

The strength of the patient's grip and his ability to raise and hold his head off the bed are helpful guides to the degree of clinical recovery. Muscle groups have varying sensitivity to relaxants. The diaphragm is the least sensitive; the trunk, extremities, neck and ocular muscles follow in increasing order of sensitivity. Therefore, if a patient can elevate his head and has a strong hand grip, his diaphragm and trunk muscles probably have recovered, enabling adequate support ventilation.

Taking a careful preoperative anesthetic and family history helps to prevent problems in surgery that arise from abnormal pseudocholinesterase activity. For example, the maternal grandmother of the patient in case 1 had had severe respiratory depression following a shoulder manipulation under general anesthesia a few years before the patient's operation. Unfortunately, the patient did not know of this incident when we were taking her history; we did not hesitate to give her succinylcholine. When a patient's diagnosis of abnormal pseudocholinesterase is made, that patient's blood relatives should be tested for abnormal enzyme activity. Any patient with a normal or lowered normal pseudocholinesterase should carry medical identification to warn anesthesia personnel of potential respiratory problems when succinylcholine is used.

Acknowledgment

I wish to thank Dr. Alex S. Moffett, Taylorsville, North Carolina, for permission to present two of his patients, cases 2 and 3, and Dr. J. Crispin Smith.

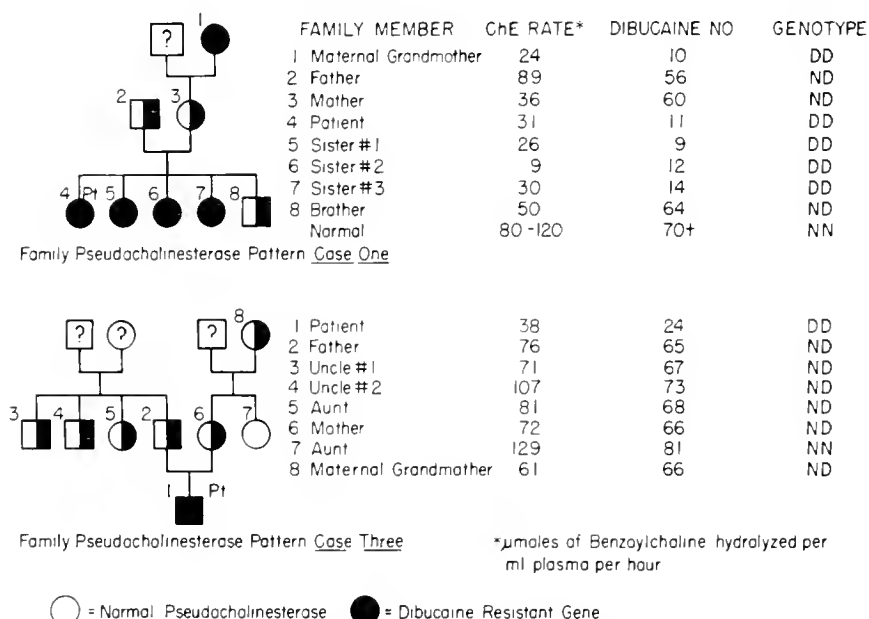


Fig. 1. Family genotypes for cases 1 and 3.

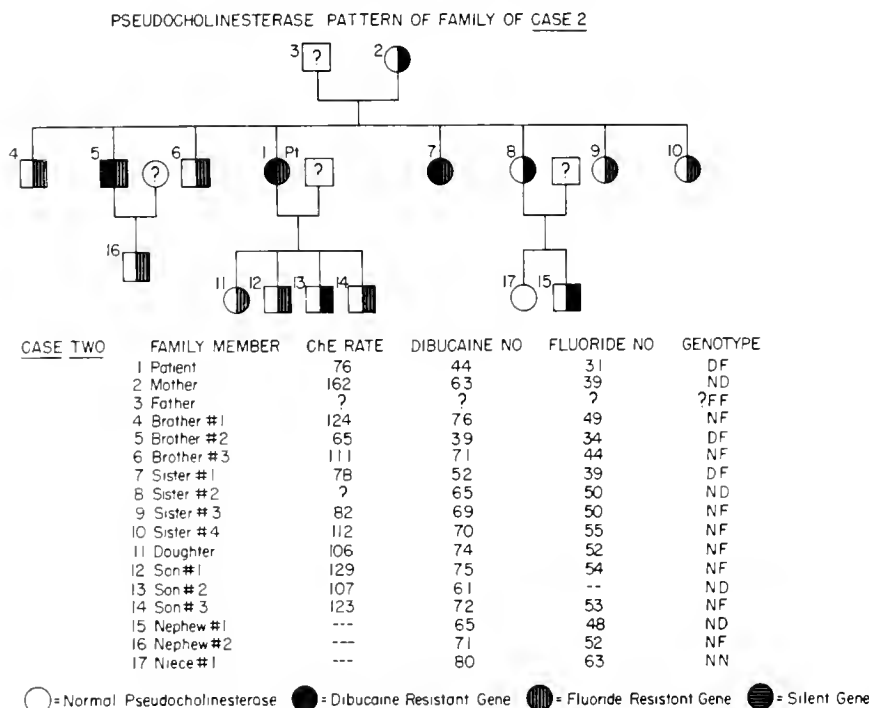


Fig. 2. Family genotypes for case 2.

the Department of Pharmacology, University of Rochester School of Medicine and Dentistry, for determining the genotypes, dibucaine numbers and cholinesterase rates for these three cases.

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There are many malingerers among hysterical subjects; but it is no less true that in certain patients of this class nutrition and excretion are reduced to the *minimum*. They maintain their nutrition on two or three figs *per diem*, and excrete less than half an ounce of urine and scarcely any feces at all. The observations of Empereur demonstrated also that these hysterical patients did not excrete one-fifth part of the normal amount of carbonic acid. The conclusion may be drawn from these facts that there exists a group of women in whom the nutritive changes are at the *minimum*; their life is almost *latent*.—*Death and Sudden Death*, P. Brouardel, 1897, pp. 26-27.

Family Practice: One Answer

Lyndon K. Jordan, M.D.*

THE developing health care delivery crisis that is occurring in the United States has been discussed within the profession for many years. It has reached such proportions that it is being discussed by the Executive and Legislative branches of our government and by millions of Americans who "can't get a physician." This shortage is both apparent to the lay public and real in the profession. Although the total number of practicing physicians in this country is, indeed, inadequate for our needs, there is a disproportionate spread within the specialties. For instance, surgeons are generally in great supply and, according to Dr. Walter C. Bornemeier,¹ past president of the American Medical Association, we continue to produce more than we need.

However, this trend does not reflect what is happening within the entire profession. In December 1973, there were 356,534 physicians in the United States. Of this number, 292,210 were involved in direct patient care. Forty-six percent of this number who are directly involved in patient care are in primary medi-

cal care—general practice, internal medicine, obstetrics, gynecology and pediatrics. General practice, with 18.7 percent,² is the largest segment of this population.

Of the 292,210 physicians involved in patient care, only 201,302 are office based and look after the daily medical needs of more than 200 million Americans who average seeing their physicians approximately four and one-half times per year. Those who feel the brunt of this burden are physicians in rural areas. More than one-fourth of America's population live in non-metropolitan areas which have only 16.5 percent of all nonfederal physicians. In addition, many patients who live in metropolitan areas travel long distances to seek medical care in small towns, either because to do so is more desirable or because of easier access.

FAMILY PRACTICE

The specialty of family practice has been given new emphasis within the medical profession and from the United States Government in the form of various grants for residency training programs. In March 1974, there were 191 family practice residency training programs in the United States. Of this number, 100 were based at community hospitals, 49 were university medical center

based and 28 were university affiliated.

According to Dr. Robert Graham, Director of Education, American Academy of Family Physicians (oral communication, March 1974), at the beginning of the 1974 academic year there were 1,771 family practice residents in training. Of this number, 756 were first-year residents who filled 84 percent of the first-year appointments available. Six-hundred fifty-three second-year residents filled 72 percent of the vacancies. The 354 third-year residents filled 39 percent of the vacancies. Eight fourth-year residents were in training. The disproportionate vacancies in the third and second year programs can be accounted for in that all family practice residencies began during the past three or four years. The specialty was first recognized in 1969, and specialty board certification was first offered in 1970.

The number of prospective family practice residents among third and fourth-year medical students is most encouraging; it is estimated that approximately 25 or 30 percent will be seeking appointments in such programs upon graduation during the next five years.

This new popularity in primary care is interesting from several points of view. First, this specialty has seldom been advanced by exis-

Read, in part, before the Section on Family Practice, North Carolina Medical Society, Pinehurst, N. C., May 19-23, 1973.

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in department faculties of the traditional specialties. The fascination of the specialty is poorly understood by professional academicians who usually are oriented quite definitely in directions other than direct patient care. This is a fault of the system rather than of individuals. Embraced for decades by medical teachers is the philosophy that honor comes to him who develops an unusual *depth* of expertise in some specific subspecialty. This philosophy has always been advanced with some justification, and it becomes the motivating force leading to the well known one-upmanship within the medical teaching profession.

The second paradox is evident when one observes that family physicians are rarely on the faculties at the typical university medical schools. There is no traditional model in this setting with whom the aspiring medical student can identify. Perhaps this problem is related to the previously mentioned philosophy regarding subspecialties, and to some rather distorted connotations of the words "depth of training." Since family physicians may not have the "depth of training" or expertise in a specific secondary or tertiary medical specialty field, they seldom receive faculty teaching appointments. Credence is seldom given to the fact that the family physician is usually a better pediatrician than the internist, a better gynecologist than the pediatrician and, in fact, a better internist than the cardiologist! It is not debatable, however, that pediatrics can best be taught by the pediatrician, gynecology by the gynecologist, and cardiology by the cardiologist. Who but the family physician is to integrate these specialties into a practical functioning unit for the thousands of smaller towns not large enough to support a battery of secondary or tertiary specialists? There is no one to speak for this large area of need. Therefore, it is surprising that the specialty has flourished among our medical students in the absence of a traditional model with whom they can identify a pattern themselves.

Third, today's medical students are more interested in patient care

than most members of the preceding generation were at the same point in training. Most students ask this question: We have clinics to take care of virtually every organ and organ system, and we have tertiary specialists who consult with the consultants, but who is going to take care of sick *people*? Apparently, it is this same question that is being asked by the lay public, the profession itself and, indeed, the Congress; all are demanding more practicing physicians for the tax dollar spent in medical education, and medical students themselves are concerned about the availability of primary care. As noted by the Family Practice Club, Duke University School of Medicine (oral communication, 1973), in many medical universities where no such faculty interest has traditionally existed, the medical students have formed family practice societies, set up primary care clinics in the surrounding communities, amassed sufficient financial resources to invite guest speakers, and have begun to exert some pressure in an organized way upon the medical school faculty to develop family medicine as a residency program and as an undergraduate track.

Traditional medical school faculty have met this entire movement with some degree of predictable reservation. This people-oriented pursuit is poorly understood by the academicians, who have restricted their view, sheltered their exposure to responsibility and retreated into one small authoritative subspecialty as a professional home, complacently leaving to someone else the responsibility of producing the broadly trained product needed and requested by the American people. A specialty of *breadth* runs counter to all that they have taught and have been taught. The negativity is also expressed by medical conservatives when any new specialty area is advanced. Mainly, anxiety and distrust are expressed for fear that some new peer group will invade still further those areas considered sacrosanct by any given specialty.

Ironically, medical students have become more vocal, and they are much more interested in policy

decisions concerning curriculum, health care systems and national health programs. It is unusual that their voice is heard and that it has been given the weight of authority that, for decades, has been reserved for the most senior attending faculty. It is a very powerful voice! Medical students have asked for family medicine, and it is largely for this reason that it is being developed.

Many contributing forces have been leading to the establishment of family medicine as a specialty and residency pursuit. In the long run, family medicine will remain a viable specialty pursuit, because there are many within our ranks (and junior ranks) who feel that it is the most rewarding and satisfying of all specialties. The American Academy of Family Physicians will continue its evangelistic crusades, firmly convinced that theirs is the most noble calling of them all. It is even more likely that there will be a very definite impact upon the traditional curriculum of American medical schools. There will be a move toward relevance of training—something that has been lacking in our system for a long time. There will be a return to the apprenticeship in certain areas of teaching, for only here can one be taught the subtleties of the profession and the various nuances of rapport and communication between the master physician and his patient. These sometimes subtle or intangible aspects can be taught only by someone who is an everyday professional providing medical care for people.

If family medicine can produce more primary care providers, the entire effort will be worthwhile; it will be one answer to our nation's growing health care problem. Moreover, if it can effect a second look at how we are training physicians, and if it can help bring about some long overdue changes, it will have performed a service to the profession that will last much longer than the specialty itself.

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Survey of Health Education in the North Carolina Public Schools

Martha Y. Martinat*

IN May 1973, the House of Delegates of the North Carolina Medical Society approved a resolution calling for greater concern on the part of local boards of education, county medical societies and practicing physicians for the promotion of courses on the venereal diseases in junior and senior high schools.¹

Cooperating with their societies, county auxiliaries found that venereal disease education seemed to vary from school to school within each local system. The Executive Committee of the Auxiliary to the North Carolina Medical Society and its president, Mrs. J. Elliott Dixon, felt that a survey of several aspects of school health education throughout the state should be taken. They, therefore, prepared a questionnaire to ascertain how many students received instruction in certain health areas, the use of educational television in health education, training of teachers and use of community health resources. The training of teachers and use of community health resources were included in the

survey because educators at a 1973 health education workshop in Florida had expressed such a need.²

RESULTS

Ninety-two of North Carolina's 150 school systems replied to the survey, representing 855,204 students, of whom 283,242 were in grades K-4; 341,402 in grades 5-9; and 178,649 in grades 10-12. Three systems did not complete questions for grades 5-9 and two did not complete the section for grades 10-12. All figures, except enrollment, are estimates.

Answers to the question, "What percentage of your enrollment (in K-4, 5-9, 10-12) receives instruction in the following topics through regular school curriculum?" are given in Tables 1-9.

Answers to the question, "Are programs on any of the above provided by other organizations (health department, police, etc.)?" were answered as follows:

K-4: Sixty-four systems utilized community resources to supplement regular curriculum. The role of the county health department in coverage of all topics, but especially den-

tal health, was reported by 36 systems. One system qualified its answers by saying that the health department furnished all health education included in its curriculum. Law enforcement officials presented safety programs in 35 systems; fire departments in 26. Other organizations presenting programs included the mental health departments, Dental Society and its auxiliary, Forest Service (fire and pollution), Junior League (drugs), Medical Society and its auxiliary (drugs, health exhibits and fairs).

5-9: Fifty-eight systems used programs presented by community organizations. Law enforcement, 57 (drugs and safety); health departments (venereal disease, sanitation, personal health, drugs and alcohol, family planning and sex education and immunization); others included fire departments, mental health associations, family life centers, Red Cross (first aid), alcohol associations, School Food Service and 4-H (nutrition), Forest Service (fire and pollution), rescue squad, drug committees and centers, Medical Society and auxiliary (venereal disease, family planning, eye safety, nutri-

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Reprint requests to 120 Sherwood Forest Drive, Winston-Salem, North Carolina 27104

on and drugs), wildlife associations (hunter safety) and Dental Society. 10-12: Forty-two systems used programs from the health departments (venereal disease, drugs and family planning) and law enforcement (driver education is taught at this level). Other organizations presenting programs included family life centers, mental health departments, fire departments, drug and alcohol centers and committees, rescue squad (water and boat safety), Kiwanis Club (drugs), School Food Service (nutrition), Medical Society and auxiliary (venereal disease, family planning, drugs and nutrition).

Answers to the questions, "What percentage of your teachers has taken accredited health education courses?" and "What percentage of your teachers has attended health education workshops?" were that health education is required for teacher certification in the elementary and intermediate grade levels. Content for the course is established by state guidelines. Ninety-two percent of the systems replying to the questionnaire reported that 1-25 percent of teachers in the upper grades was estimated to have taken course in health education; fifty-three percent estimated that 1-25 percent of their teachers had attended health education workshops and conferences.

In an attempt to assess the use of educational television, the question, "What percentage of your students is viewing the 'Inside/Out Series'?"³ was included under questions for grades K-4. North Carolina was one of 28 states presenting this new series this year — thirty 15-minute color programs. Situations are presented which require decisions on the part of the eight to ten-year-old audience. Wallace Ann Wesley, Director, Department of Health Education, AMA, was one of the planners and designers of the series, which was created under the supervision of the National Instructional Television Center. The series will be repeated for two additional years on North Carolina's educational television stations.

In its first year, the "Inside/Out

Series" is being viewed by 1-25 percent of the eligible children in 51 of the 92 systems replying to the K-4 questions. Seventeen other systems have reported that 26-50 percent see the series. Six have reported 51-75 percent; 76-100 percent was reported by Moore (all 3-5 grades), Mecklenberg (all third and fourth grades), Salisbury City (all 4-6 grades) and Columbus County. Fourteen systems left the question unanswered or commented on "poor reception."

CONCLUSIONS

Inconsistency and fragmentation describe health education in North Carolina schools. This description coincides with the results of a nationwide sampling of schools taken during a health education study in Washington, D. C. during 1961-1971.⁴

Although many systems use community resources, almost 30 percent do not. The Division of Health and Physical Education of the State Department of Instruction has urged

Table 1
Nutrition

Grade Level	No.	0%	1-25%	26-50%	51-75%	76-100%
K-4	SYSTEMS PUPILS	1 589	2 4,375	6 17,506	6 11,622	77 249,150
5-9	SYSTEMS PUPILS		2 7,233	7 18,493	13 36,833	67 278,843
10-12	SYSTEMS PUPILS		31 75,755	35 67,556	11 12,446	13 22,892

Table 2
Mental Health (Coping with Stress)

Grade Level	No.	0%	1-25%	26-50%	51-75%	76-100%	Unanswered
K-4	SYSTEMS PUPILS	1 7,369	22 66,112	21 88,140	20 59,178	21 60,168	7 2,275
5-9	SYSTEMS PUPILS		13 41,963	13 43,535	24 65,778	39 190,126	
10-12	SYSTEMS PUPILS	1 2,700	31 62,966	32 75,238	14 18,309	8 15,463	4 3,973

Table 3
Communicable Disease (Including VD)

Grade Level	No.	0%	1-25%	26-50%	51-75%	76-100%	Unanswered
5-9	SYSTEMS PUPILS		3 12,881	12 31,540	20 57,408	49 202,205	5 37,368
10-12	SYSTEMS PUPILS	1 2,700	17 26,345	29 86,341	21 32,677	17 28,197	5 2,389

Table 4
Exercise and Physical Fitness

Grade Level	No.	0%	1-25%	26-50%	51-75%	76-100%
K-4	SYSTEMS PUPILS			1 2,600	13 21,124	78 260,518
5-9	SYSTEMS PUPILS		1 4,200	1 1,153	8 22,832	79 313,217
10-12	SYSTEMS PUPILS		18 27,647	33 59,671	16 24,095	23 67,236

Table 5
Safety*

Grade Level	No.	0%	1-25%	26-50%	51-75%	76-100%	Unanswered
K-4	SYSTEMS PUPILS			8 13,173	18 35,068	64 233,433	2 1,468
5-9	SYSTEMS PUPILS		1 4,200	3 8,293	13 35,052	72 293,857	
10-12	SYSTEMS PUPILS			11 13,230	18 36,133	61 129,286	

* In a breakdown under "Safety" for the topics of Fire, Water, Highway, and Poison, coverage of Fire and Highway was reported "good." There was little instruction in water safety except on the coast. Poison safety instruction was considered "poor."

Table 6
Cleanliness - Personal and Environmental (Pollution)

Grade Level	No.	0%	1-25%	26-50%	51-75%	76-100%
K-4	SYSTEMS PUPILS		1 938	5 15,985	13 19,936	73 236,383
5-9	SYSTEMS PUPILS		1 1,153	5 22,247	14 33,397	69 284,605
10-12	SYSTEMS PUPILS		2 4,293	5 15,985	9 19,956	74 138,415

Table 7
Drug and Alcohol Abuse

Grade Level	No.	0%	1-25%	26-50%	51-75%	76-100%	Unanswered
K-4	SYSTEMS PUPILS	4 7,556	28 70,282	19 59,410	22 55,507	15 70,407	4 20,808
5-9	SYSTEMS PUPILS			7 25,163	22 63,159	60 253,080	
10-12	SYSTEMS PUPILS	1 2,700	12 17,653	15 38,684	27 41,319	30 72,844	5 5,449

Table 8
Dental Health

Grade Level	No.	0%	1-25%	26-50%	51-75%	76-100%
K-4	SYSTEMS PUPILS		1 2,600	4 12,274	13 24,966	74 243,502
5-9	SYSTEMS PUPILS		4 10,691	8 63,644	24 68,542	53 198,525
10-12	SYSTEMS PUPILS	6 25,185	32 61,664	22 41,644	16 30,276	14 19,880

Table 9
Family Planning

Grade Level	No.	0%	1-25%	26-50%	51-75%	76-100%	Unanswered
5-9	SYSTEMS PUPILS	8 64,566	31 108,532	30 72,992	13 53,658	4 31,592	6 10,062
10-12	SYSTEMS PUPILS		36 70,299	26 44,414	13 21,108	11 38,359	4 4,469

each system to appoint a health coordinator. As of September, 1973, four systems — Alamance, Greenville City-Pitt, Jackson and Warren — have had health coordinators funded by the North Carolina Drug Authority to develop curriculum and inservice teacher training, coordinate community resources, give demonstrations to other school units and form a community health council. Three of these four systems replied to the survey.

The role of educational television shows great promise and should be made available to all schools.

Standards in health education for the schools should be established. The expertise of the Medical Society should be utilized in this endeavor.

Standardized curriculum, such as the conceptual system of health education already developed by the 3M Visual Products Division,⁵ should be evaluated.

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That is a question [At what moment does life cease?] which looks very easy to answer. There is not one of us, Gentlemen, who has not been present, at least once, at this final scene of every human existence, who has not seen a dying man draw his last breath. The stoppage of respiration, or to use the customary expression, the last breath, is, as a matter of fact, considered by the public as the unequivocal sign of the disappearance of life. This is a grave error, Gentlemen, for many persons who no longer breathe have been recalled to life by means of care and skill. The moment of death cannot therefore be assumed to be identical with cessation of respiration.—*Death and Sudden Death*, P. Brouardel, 1897, p. 18.

Editorials

AN OUNCE OF PREVENTION?

Elsewhere in this issue (page 614) a notable effort of the Auxiliary of the North Carolina Medical Society is addressed to the scope of health information in our state's school systems. The figures given admittedly reflect partial (61 percent) response to a questionnaire, and a comparison of a complete school system with others in the state could not be made. However, the conclusion that "inconsistency and fragmentation describe health education in North Carolina schools" appears inescapable. Wherein lies the solution?

As a medical society, we have long espoused the dictum that "an ounce of prevention is worth a pound of cure." On the balance scale of health care, nonetheless, we have directed our interests, efforts and resources toward quantum increases in pounds of cure. One might question whether the proverbial "ounce" is not more nearly a "dram." Indeed, do we truly give a dram for prevention? Our stated goals and our observed behaviors are not congruent. We have paid lip service to the axiom that the most effective mode of prevention of many disorders is thorough adequate education of the individual at risk for the disorder. The Auxiliary has clearly shown that we have not translated our intent into action, much less into actuality!

In this vein, we certainly must question whether the health information topics considered in the school survey are truly applicable to primary prevention of significant health problems. The relevance of each of all these topics to disease prevention (more positively: to health enhancement) may be firmly established in either of two ways:

1. In utilization of risk-factor analysis, specific age groups may be identified as being "at risk" for specific problems, and intervention measures may be developed. In good medical practice, intervention is begun prior to development of risk. Interestingly, the most productive intervention points for most common and serious adult problems lie in childhood. The consequences of lack of knowledge or appropriate behavior in any one of the health information topics considered in the Auxiliary's survey could be developed at length. As a skeletal example, we recognize that establishment of regular exercise patterns, appropriate dietary intake, abstinence from tobacco and other toxins, and constructive responses to stress are likely more effective in avoidance of coronary artery disease than is the attempt to institute similar

measures once the problem is manifest. Grades K-12 appear more fertile ground for behavior modification than do coronary care units.

2. In more immediate terms, the existence of serious problems within the school age population itself lends credence to the necessity for health education. The prevalence of overall drug usage probably is increasing, and the age group involved is progressively younger. Venereal disease, pregnancy, abortion and the stresses inherent in each demonstrably are on the upswing. Suicide remains the third most common cause of adolescent mortality. Accidents, the second most common cause, appear to be less related to health education; we cannot, however, escape the intertwining of these existing problems with conscious or subconscious motivation toward accidents. Thus, in large measure, significant portions of the above-mentioned problems are preventable through effective education in advance of conditions directly facing the school age group.

If we accept the problem as being the failure to institute salient principles or primary intervention (in this case, health education), the solution appears to be simple. There are, at the same time, two additional factors—one philosophic, and one pragmatic—to be considered. The approaches suggested by the Auxiliary in its report touch on both.

Philosophically, we as physicians must determine our responsibility and accountability for health education in the school systems. Our present attitude may be glimpsed in the delegation of this study to our Auxiliary. At any rate, its members have done their job well, and, in the doing, have presented a challenge to us to act on their findings. It remains for us to interact responsibly with the Board of Education and with the Board of Health at the state level to develop and institute a long-overdue health curriculum to include: (1) medically-sound factual material, (2) adequate preparation and continuing education for teachers, (3) pertinent topic introduction at appropriate grade levels, (4) utilization of community and state resources and innovative teaching methods, and (5) meaningful continuity and emphasis on health education from kindergarten through senior high school.

At the pragmatic level, it must be continually borne in mind that health information is *not* synonymous with health education. "Information" is a process of teaching. "Education" is a demonstrated change in behavior as a result of incorporating and then acting

October 28-November 1

Current Concepts in General Radiology
Place: Southampton Princess Hotel, Southampton, Bermuda
Program Chairman: Richard G. Lester, M.D., Professor and
Chairman of Radiology, Duke University Medical Center.
Guest speakers will include: Robert G. Fraser, M.D.,
Professor and Chairman of Radiology, McGill University
Medical School, Montreal, Canada; John A. Evans, M.D.,
Professor and Chairman of Radiology, Cornell University
Medical College; William B. Seaman, M.D., Professor
and Chairman of Radiology, Columbia University College
of Physicians and Surgeons, New York, N. Y.; Harold G.
Jacobson, M.D., Professor and Chairman of Radiology,
Albert Einstein College of Medicine (MHMC), Bronx,
New York; and David H. Baker, M.D., Director of
Radiology, Babies Hospital, Professor of Radiology, Co-
lumbia University College of Physicians and Surgeons,
New York, N. Y. Subject matter will cover Pediatric
and Adult Radiology of the Chest, Genitourinary Tract,
Gastrointestinal Tract and Musculoskeletal system.

Fee: \$200

Credit: Twenty-three hours AMA "Category One" accredi-
tation

For Information: Robert McLelland, M.D., Department of
Radiology, Box 3808, Duke University Medical Center,
Durham 27710

November 4-6

Amputations and Prosthetics

Place: Holiday Inn West, Durham

Sponsor: American Academy of Orthopaedic Surgeons,
Chicago, Illinois

Fee: \$150

For Information: Frank W. Clippinger, M.D., Box 2919,
Duke University Medical Center, Durham 27710

November 7-9

North Carolina Academy of Family Physicians Annual
Meeting

Place: Sheraton Crabtree Motor Inn, Raleigh

For Information: A. M. Alderman, Jr., M.D., 233 Bryan
Building, Raleigh 27605

November 13

Burn Symposium

Place: Babcock Auditorium, Time: 12:30-5:30 p.m.

Fee: \$10

Credit: 5 hours

For Information: Emery C. Miller, M.D., Associate Dean
for Continuing Education, Bowman Gray School of Medi-
cine, Winston-Salem 27103

November 15-16

Anesthesiology Fall Seminar

Place: Charlotte Memorial Hospital Auditorium

Fee: \$40

For Information: Dr. H. A. Ferrari, Chairman, Department
of Anesthesiology, Charlotte Memorial Hospital, P. O.
Box 2554, Charlotte 28201

December 3-4 & 5-6

The Nursing Audit

Place: Dec. 3-4, Humanities Lecture, UNC-Asheville; Dec.
5-6, Southwest Technical Institute, Sylva

Sponsor: Health Education Commission of Western North
Carolina

Fee: \$7

For Information: Mrs. Marian S. Martin, P. O. Box 7607,
Asheville 28807

December 5

American College of Physicians—North Carolina Society of
Internal Medicine, Annual Meeting

Place: Holiday Inn Four Seasons, Greensboro

For Information: John T. Sessions, Jr., M.D., Department
of Medicine, UNC School of Medicine, Chapel Hill
27514 or John L. McCain, M.D., Wilson Clinic, Wilson
27893

December 5-6

2nd North Carolina Postgraduate Course on Pulmonary
Disease

Place: Velvet Cloak Inn, Raleigh, N. C.

Fee: \$25—Enrollment is limited. Applications will be ac-
cepted in order received.

Rondomycin (methacycline HCl)

CONTRAINDICATIONS Hypersensitivity to any of the tetracyclines.

WARNINGS Tetracycline usage during tooth development (last half of pregnancy to eight years) may cause permanent tooth discoloration (yellow-gray-brown), which is more common during long-term use but has occurred after repeated short-term courses. Enamel hypoplasia has also been reported. **Tetracyclines should not be used in this age group unless other drugs are not likely to be effective or are contraindicated.**

Usage in pregnancy (See above **WARNINGS** about use during tooth development.) Animal studies indicate that tetracyclines cross the placenta and can be toxic to the developing fetus (often related to retardation of skeletal development). Embryotoxicity has also been noted in animals treated early in pregnancy.

Usage in newborns, infants, and children (See above **WARNINGS** about use during tooth development.)

All tetracyclines form a stable calcium complex in any bone-forming tissue. A decrease in fibula growth rate observed in premature infants given oral tetracycline 25 mg/kg every 6 hours was reversible when drug was discontinued.

Tetracyclines are present in milk of lactating women taking tetracyclines.

To avoid excess systemic accumulation and liver toxicity in patients with impaired renal function, reduce usual total dosage and, if therapy is prolonged, consider serum level determinations of drug. The anti-anabolic action of tetracyclines may increase BUN. While not a problem in normal renal function, in patients with significantly impaired function, higher tetracycline serum levels may lead to azotemia, hyperphosphatemia, and acidosis.

Photosensitivity manifested by exaggerated sunburn reaction has occurred with tetracyclines. Patients apt to be exposed to direct sunlight or ultraviolet light should be so advised, and treatment should be discontinued at first evidence of skin erythema.

PRECAUTIONS If superinfection occurs due to overgrowth of nonsusceptible organisms (including fungi), discontinue antibiotic and start appropriate therapy.

In venereal disease, when coexistent syphilis is suspected, perform darkfield examination before therapy, and serologically test for syphilis monthly for at least four months.

Tetracyclines have been shown to depress plasma prothrombin activity; patients on anticoagulant therapy may require downward adjustment of their anticoagulant dosage.

In long-term therapy, perform periodic organ system evaluations (including blood, renal, hepatic).

Treat all Group A beta-hemolytic streptococcal infections for at least 10 days.

Since bacteriostatic drugs may interfere with the bactericidal action of penicillin, avoid giving tetracycline with penicillin.

ADVERSE REACTIONS **Gastrointestinal** (oral and parenteral forms): anorexia, nausea, vomiting, diarrhea, glossitis, dysphagia, enterocolitis, inflammatory lesions (with monilial overgrowth) in the anogenital region.

Skin: maculopapular and erythematous rashes, exfoliative dermatitis (uncommon). Photosensitivity is discussed above (See **WARNINGS**).

Renal toxicity: rise in BUN, apparently dose related (See **WARNINGS**).

Hypersensitivity: urticaria, angioneurotic edema, anaphylaxis, anaphylactoid purpura, pericarditis, exacerbation of systemic lupus erythematosus.

Bulging fontanels: reported in young infants after full therapeutic dosage, have disappeared rapidly when drug was discontinued.

Blood: hemolytic anemia, thrombocytopenia, neutropenia, eosinophilia.

Over prolonged periods, tetracyclines have been reported to produce brown-black microscopic discoloration of thyroid glands; no abnormalities of thyroid function studies are known to occur.

USUAL DOSAGE **Adults**—600 mg daily, divided into two or four equally spaced doses. More severe infections: an initial dose of 300 mg followed by 150 mg every six hours. 300 mg every 12 hours. Gonorrhea: In uncomplicated gonorrhea, when penicillin is contraindicated, Rondomycin (methacycline HCl) may be used for treating both males and females in the following clinical dosage schedule: 900 mg initially, followed by 300 mg q.i.d. for a total of 5.4 grams.

For treatment of syphilis, when penicillin is contraindicated, a total of 18 to 24 grams of Rondomycin (methacycline HCl) in equally divided doses over a period of 10-15 days should be given. Close follow-up, including laboratory tests, is recommended.

Eaton Agent pneumonia: 900 mg daily for six days.

Children—3 to 6 mg/lb. day divided into two to four equally spaced doses.

Therapy should be continued for at least 24-48 hours after symptoms and fever have subsided.

Concomitant therapy Antacids containing aluminum, calcium or magnesium impair absorption and are contraindicated. Food and some dairy products also interfere. Give drug one hour before or two hours after meals. Pediatric oral dosage forms should not be given with milk formulas and should be given at least one hour prior to feeding.

In patients with renal impairment (see **WARNINGS**), total dosage should be decreased by reducing recommended individual doses or by extending time intervals between doses.

In streptococcal infections, a therapeutic dose should be given for at least 10 days.

SUPPLIED Rondomycin (methacycline HCl) 150 mg and 300 mg capsules, syrup containing 75 mg/5 cc methacycline HCl.

Before prescribing, consult package circular or latest PDR information.

Rev 67



WALLACE LABORATORIES
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Sponsors: North Carolina Thoracic Society, North Carolina Lung Association and North Carolina Academy of Family Physicians
Credit: This program is acceptable for 10 elective hours by the American Academy of Family Physicians.
For information: C. Scott Venable, Executive Director, North Carolina Lung Association, P. O. Box 127, Raleigh 27602 (919-832-8326)

December 6-7

What's New in Newborn Care?
Place: Babcock Auditorium
Fee: \$45
Credit: 9 hours AAFP credit
For Information: Emery C. Miller, M.D., Associate Dean for Continuing Education, Bowman Gray School of Medicine, Winston-Salem 27103

December 11-12

Hospital Emergency Room Services and Ambulatory Care
Place: Winston-Salem Hyatt House and Convention Center, Winston-Salem
Sponsors: North Carolina Hospital Association and the North Carolina Medical Society
Program: Designed for hospital administrators, trustees and physicians.
For Information: Mrs. Diane Turner, North Carolina Hospital Association, P.O. Box 10937, Raleigh 27605

January 24-25

Surgical Infections
Fee: \$75
Credit: 12 hours
For Information: Emery C. Miller, M.D., Associate Dean for Continuing Education, Bowman Gray School of Medicine, Winston-Salem 27103

January 31-February 1

North Carolina Medical Society 1975 Conference for Medical Leadership
Place: State Society Headquarters Building, Raleigh
Program: Designed especially for Society Officers and other members who carry leadership responsibility. Open to all interested Society members.
For Information: Mr. William N. Hilliard, Executive Director, North Carolina Medical Society, P. O. Box 27167, Raleigh 27611

February 14-15

Medical Ethics Symposium
Place: Babcock Auditorium
Fee: \$30
Credit: 15 hours
For Information: Emery C. Miller, M.D., Associate Dean for Continuing Education, Bowman Gray School of Medicine, Winston-Salem 27103

February 19

Vingate Johnson Memorial Lecture
Place: Babcock Auditorium, Time: 11:00 a.m.
For Information: Emery C. Miller, M.D., Associate Dean for Continuing Education, Bowman Gray School of Medicine, Winston-Salem 27103

March 17-21

Tutorial Postgraduate Course: Radiology of the Gastrointestinal Tract
Place: Governors Inn, Research Triangle Park (between Durham and Raleigh, near the airport.)
Program: Designed for radiologists, but open to other physicians in training or practice. Emphasis on personalized, tutorial type teaching, with ample opportunity for discussion. Two 80-minute tutorial sessions each morning, and one in the afternoon; 12 registrants will join one faculty member in a separate quiet room with view-boxes for organized film reading-discussions and case presentations. Each registrant will have a total of 14 different tutorial sessions. One hour "Panel" presentation-discussion each afternoon. Guest faculty include: Drs. Charles A. Bream, Harley C. Carlson, Joseph T. Ferrucci, Jr., Roscoe E. Miller, Jerry C. Phillips, Bernard S. Wolf, and, from Kings College Hospital, London, England, Dr. John Laws, Chairman, Department of Radiology.

Fee: \$300; enrollment limited.

Credit: 28 hours AMA "Category One" accreditation

For Information: Robert McLelland, M.D., Department of Radiology, Box 3808, Duke University Medical Center, Durham 27710

Continuing Education via Satellite

The following programs will be received live from the ATS-6 communications satellite, by the Veterans' Hospitals at Fayetteville, Oteen and Salisbury on the dates indicated. Sessions are open to all physicians and other interested health professionals.

October 16—1 p.m. "CPR"; 2 p.m. "POMR"

October 23—1 p.m. & 2 p.m. "Acute Respiratory Failure"

October 30—1 p.m. "Coronary Care Unit"

November 1—1 p.m. & 2 p.m. "Cardiac Rehabilitation"

November 13—1 p.m. "Hypertension"

November 20—1 p.m. "Radiology Conference"

November 27—1 p.m. "Patient Histology Tissue Conference"

Additional sessions are scheduled for the following months.
For Information: Fayetteville—Mr. Kenneth Gath; Oteen—Stewart Scott, M.D. or Mary Ellen Lutz, R.N.; Salisbury—Mr. Dante Spagnolo

Continuing Education for Nurses

October 21-23—Problem-Oriented Medical Record System

October 23-25—The Nursing Audit

November 4-6—The Nurse: Planning Classes for Expectant Parents

November 6—A Practical Approach to Drug Interactions

November 18-22—Planning Patient Care

For Information: Judith E. Wray, Administrative Secretary, Continuing Education Program, UNC School of Nursing, Chapel Hill 27514

* * *

Cancer Information by Phone

A toll free phone call to the Southern Medical Association Cancer Education Service, (1-800-231-6970), makes cancer information available by phone to physicians in North Carolina and other states in the Southern Medical Association area. Tapes must be requested by number. For a cross indexed list of over 260 tapes, call the above number, identify yourself by name, address, city and state, and request a copy of the index.

New Directory Available

The second edition (OP-414) of the *Directory of Self-Assessment Programs for Physicians* is now available for \$1.00 from the Order Department, American Medical Association, 535 N. Dearborn, Chicago, Illinois 60610. The new edition lists six new self-assessment programs in: Allergy, Cardiology, Chest Diseases, Colorectal & Anorectal Surgery, Emergency Medicine, and Neurological Surgery. A total of 21 programs is sponsored by specialty societies, a county medical society and one university. Each program, listed by topic and sponsor, is described with regard to: intended participant, sites and time of testing, dates of first test & most recent revision, objectives and content, format, time required, method of scoring, aids to learning provided, fees charged and where to write for further information.

* * *

In Contiguous States

December 5-8

Core Curriculum: Clinico-Pathologic Correlations in Cardiovascular Disease

Place: Williamsburg Conference Center, Williamsburg, Virginia

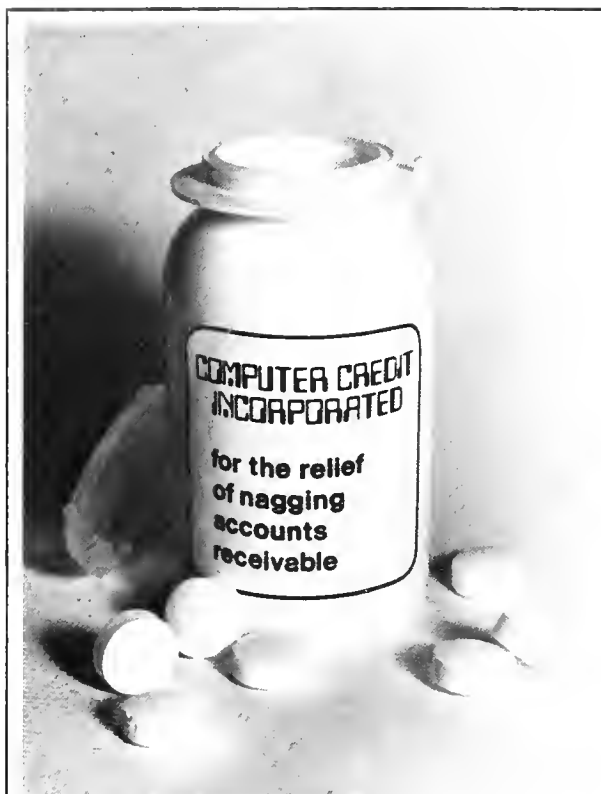
For Information: Miss Mary Anne McInerney, Director, Department of Continuing Education Programs, American College of Cardiology, 9650 Rockville Pike, Bethesda, Maryland 20014

December 6-8

Neurologic Problems of Infancy and Childhood

Place: Cascades Meeting Center, Williamsburg, Virginia

Sponsors: University of Virginia School of Medicine; Medi-



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Enrollment limited to 80 registrants

For Information: Dr. Ronald B. David, Medical College of Virginia, Box 211, MCV Station, Richmond, Virginia 23298

Items submitted for listing should be sent to: WHA? WHEN? WHERE?, P.O. Box 8248, Durham, N. C. 27704, by the 10th of the month prior to the month in which they are to appear.

AUXILIARY TO THE NORTH CAROLINA MEDICAL SOCIETY

LEGISLATION

Perhaps today, as at no time in history, have the American people been so aware of the governmental process in this country. It goes without saying that the sensationalism of "Watergate" and the you-are-there coverage of television have made the political process as much a part of the household as the daily weather report.

The Auxiliary to the North Carolina Medical Society, working with national headquarters, is eager that its members be informed far beyond what is read in the newspapers and seen on television. The health services in this country are dependent upon good legislation, and good legislation comes from intelligent voting—first on the part of the electorate, and then by those who have been elected. The myth that the AMA, its feet supposedly mired in the muddy backwash of 18th century thought, is the enemy of the people, can only be countermanded by a thorough knowledge of what is going on. This is what the legislative arm of the Auxiliary attempts to do through the various means at its disposal.

The legislative chain of command within the Woman's Auxiliary to the AMA includes the national chairman of legislation, the regional chairman, who in turn keeps in touch with the state chairman, who currently in North Carolina is Mrs. Charles Hoffman of Fayetteville. She keeps in touch with the county chairmen throughout the state. The role of the county chairman is to inform her membership of pertinent legislation. When such legislation is of an emergency nature—when telegrams and letters to congressmen and senators are in order—the county chairman makes use of a telephone committee which notifies all the membership, requesting that telegrams and letters be sent to their appropriate representatives. An example this past year was the opposition to the \$1.5 billion Senate Health Maintenance Organization (HMO) bill. Nationwide action by Auxiliary members contributed to a compromise costing only \$375 million. Action of this sort isn't mandatory or partisan; it's what is in the best interest of medicine and the taxpayer.

Among the many means of distributing legislative information to the members of the Auxiliary are

the "Legsline" newsletters which deal with current health legislation. They go directly to presidents and presidents-elect of state medical societies as well as to state legislative chairmen. In North Carolina, the "Tarheel Tandem," the quarterly Auxiliary newsletter, reports on what is pertinent from a long range view. Many members of the Auxiliary are members of MEDPAC-AMPAC, the state and national medical political action committees, respectively, and much is learned through them. So, *know your candidates!*

Political action committees are currently held as suspect by some, but AMPAC and the state subsidiaries have done wonders in informing the medical communities. AMPAC is interested in electing honest candidates to the state legislature and to Congress. It is interested in the qualified "friends of medicine," but much more than that, it is interested in candidates who will look at both sides of the question—not just those who will vote "right."

Concerning our contribution, the monies are divided equally between MEDPAC and AMPAC, but often the AMPAC share is returned to the state if a request for additional support of a candidate in the state needs it and AMPAC decided that it is a worthwhile investment. The candidates ask for help from MEDPAC, and then the MEDPAC committee decides whom to support. The MEDPAC board is non-partisan, equally divided between Democrats and Republicans. There are three Auxiliary members on the board.

In a time when the news media are full of abbreviated jargon, the Auxiliary is interested in an informed membership. How will I know an HMO when I see one? Health Maintenance Organizations take many shapes. They are a legal entity which provides a specified range of medical care services to a voluntarily enrolled population. What is AHEC? Area Health Education Centers will train residents away from the university medical centers on the theory that physicians tend to stay where they train, thus spreading the physicians around. What's going to happen to PSRO? The AMA House of Delegates voted not to ask for repeal of the Professional Standards Review Organization law, but for modification. The Congress is receptive to the idea in hopes of making NHI more palatable.

With National Health Insurance (NHI), are we heading toward socialized medicine? Not if President Ford has anything to do with it. There are numerous proposals to be voted upon, and doubtless the end result will be a compromise. What sort of compromise depends upon the leanings of Congressional members at the time the bill is passed. The AMA's medicredit plan will be all inclusive medical care, carried out through voluntary private health insurance, regardless of ability to pay. The Administration's Comprehensive Health Insurance Plan is threefold: (1) for the employed (2) for the unemployed and low income groups, and (3) a new kind of Medi-

care. Not unlike Mediredit, it has those who are able sharing the cost of insurance. The Health Security Act, sponsored by Senator Edward Kennedy, would be a compulsory insurance plan and would be financed by special social security payroll, self-employment taxes and federal general revenue. The latter would be closest to socialized medicine.

Thus, the Auxiliary membership is informed, and from this information it draws reasonable conclusions based on knowledge, not intuition. Women — physicians' wives—do have a place in government if they want it. Interesting to note, the newly appointed national Chairman of the Republican Committee is a woman — a physician's wife — Mary Louise Smith, from Iowa.

News Notes from the—

DUKE UNIVERSITY MEDICAL CENTER

Have medical scientists overlooked subtle and perhaps common errors in the body's mechanism for regulating the production and breakdown of fat?

Do these inherited defects underlie the tendency within certain families toward obesity and early heart and artery disease, the nation's major killers?

Has fat metabolism in fat storage cells been underestimated and inadequately studied in relation to high blood pressure, heart attacks and strokes?

With the aid of a \$22,000 grant from the National Foundation-March of Dimes, Dr. Robert M. Bell, an assistant professor of biochemistry at Duke, will be seeking the answers to these and other related questions in experiments he will conduct here during the next year.

Using isolated fat cells from well-fed and fasting rats, Bell will attempt to verify opposite regulatory effects of two hormones, insulin and noradrenaline, on the activity of fatty acid activating enzyme (FAAE). Among other hormones he will examine in trying to pin down the exact mechanisms by which any or all of them alter fat cell FAAE activity are glucagon, growth hormone, ACTH and prostaglandins.

* * *

Thirteen new physicians' associates have decided to begin their careers in North Carolina.

The thirteen are among 43 recent graduates of the medical center's Physician's Associate Program—the largest graduating class in the program's nine-year history. They bring to 193 the total number of Duke graduate physician's associates (PAs), and to 53 the total number of graduates employed in North Carolina.

Frederick S. Lipman has accepted a position with the Garner Professional Center in Garner, about ten miles south of Raleigh.

Russell E. Mitchell will be employed by the

Norris-Biggs Clinic of Rutherford Hospital in Rutherfordton, about 50 miles southeast of Asheville.

William G. Vaasen will be assisting physicians at Drexel Medical Associates, a family practice group in the town of Drexel with a population of 1,431—some 15 miles west of Hickory.

Bound for the community of Lawndale is Paul E. Stout, who will be working with Dr. Richard M. Maybin. Lawndale, ten miles north of Shelby, has a population of 544.

Seven of the graduates will remain in Durham.

William F. Smith is working with a local cardiologist, Dr. D. Edmond Miller.

The Durham Veterans' Administration Hospital has signed on Stephen J. Cox. Mrs. Madeleine Fraley, Preston J. Keeler, Carol J. Phillips, Delmar L. Shelton and James M. Schmidt will be assisting physicians at Duke.

Moving to Asheville, Robert L. Jackson will be working with family practitioner, Dr. Claude E. Steen. William H. Morris, who also is a registered pharmacist, has taken a position with Revco Pharmacy in Fayetteville.

* * *

Eight new assistant professors have been named to the faculty of the Medical Center.

Six of the appointments came in the Department of Radiology and one each came in the Department of Medicine and Health Administration.

Named in radiology were Drs. Roger W. Byhardt, Peter J. Dempsey, Americo A. Gonzalvo, Robert A. Older, Michael Oliphant and Moody D. Wharam Jr. Appointed in Health Administration and Medicine were Thomas J. Delaney and Dr. John J. Gallagher, respectively.

* * *

Dr. Drew Edwards and Dr. Lea O'Quinn have been named administrative director and medical director, respectively, of the Developmental Evaluation Clinic.

They succeed Dr. Ann Alexander who resigned to accept a post in San Antonio, Tex.

Edwards, a clinical psychologist, received his Ph.D. from Florida State University in 1972. Since September of that year, he has been a staff member of the clinic, serving for the last year as assistant director.

Dr. O'Quinn was awarded an M.D. from Duke in 1965 and completed an internship in pediatrics at Duke in 1966. Before beginning a residency in pediatrics at Duke in 1970, she worked in health department clinics located in Denver, Colo.



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News Notes from the—

**BOWMAN GRAY SCHOOL
OF MEDICINE
WAKE FOREST UNIVERSITY**

Dr. Charles E. McCall, associate professor of medicine, is the recipient of a Research Career Development Award from the National Institute of Allergy and Infectious Diseases.

Dr. McCall is engaged in research on the ability of white blood cells to fight bacteria and the means used to kill the bacteria.

He plans to spend a year under the grant studying in England with Dr. Peter Lachmann, an immunologist at the Postgraduate Medical School atammersmith, London.

Dr. McCall is the third member of the Bowman Gray faculty currently holding a career development grant.

* * *

Eighty-nine first-year students have enrolled for the medical school's 1974-1975 academic year.

The new class, selected from 3,915 applicants, includes students from 18 states and one foreign country. Forty-six North Carolinians are in the class.

The class has the largest female contingent (20) in the school's history. Seven members of the class are black Americans.

Total enrollment, also the largest in the school's history, is 349 medical students and 73 graduate students.

* * *

Dr. Thomas B. Clarkson, professor and chairman of the Department of Comparative Medicine, has been appointed to a one-year term on the Animal Resources Advisory Committee of the National Institutes of Health's Division of Research Resources.

Dr. Clarkson previously served a four-year term on the committee. He also serves on the advisory board of the University of Washington Primate Center.

* * *

Dr. Courtland H. Davis, Jr., professor of neurosurgery, recently was elected chairman of a subcommittee of the Continuing Education Committee of the American Medical Association.

* * *

Dr. Earl Watts, associate professor of medicine, has been chosen as a recipient of a \$5,000 scholarship grant from the Sloan Foundation to develop self-teaching aids in cardiology.

* * *

Eighty-six physicians recently joined the house staff of North Carolina Baptist Hospital and the Bowman Gray School of Medicine. The house staff now totals 203, the largest number of residents and interns ever to participate in the medical center's training programs.

News Notes from the—

**UNIVERSITY OF NORTH CAROLINA
DIVISION OF HEALTH AFFAIRS**

The country's most extensive collection of information on family planning programs, abortion clinics and population is housed in the Carolina Population Center at UNC at Chapel Hill. A part of the Technical Information Service (TIS) Program Office, the Population Center's library contains more than 4,000 books, 500 serial publications and 10,000 pamphlets, periodicals and research reports in the field of population studies. The material is readily available to community planners, researchers and students throughout the state.

* * *

The responsibilities of the sex counselor is the subject of a new booklet which defines human sexuality and explores the interplay between society's values and personal values, between the counselor and the client.

"Introduction to Sexual Counseling" is written by Robert Wilson of the Carolina Population Center at UNC in Chapel Hill and is supported by the N. C. Department of Human Resources and the Statewide Family Planning Program.

In the UNC School of Dentistry, the following new faculty have been appointed:

Caswell A. Evans, Jr., has been appointed assistant professor, Department of Dental Ecology. He has been director of research and evaluation and chief of dental services for HEALTHCO., Inc. in Soul City for the past year. A graduate of Franklin and Marshall College, he holds the D.D.S. from Columbia University and M.P.H. from the University of Michigan.

John R. Hansel has been named an assistant professor, Department of Removable Prosthodontics. He completed his masters degree at Georgetown University this year. He received his undergraduate education at St. Joseph's College and his dental training at the University of Pennsylvania.

James Edwin Noonan, Jr., has been appointed assistant professor, Department of Fixed Prosthodontics. For the past two years he has been an associate to Dr. Ray Hailey of the Cody Dental Group in Denver, Colo. A graduate of the University of Colorado, he holds the D.D.S. degree from Case Western Reserve University.

Ronald P. Strauss, former chief investigator in a dental health education research project at the University of Pennsylvania, has been appointed assistant professor in the Department of Dental Ecology. He holds the B.A. from Queens College, D.M.D. from the University of Pennsylvania School of Dental Medicine, and the M.A. from the University of Penn-

sylvania Graduate School of Arts and Sciences where he has work for a Ph.D. in progress.

Outdated, detrimental or generally unconventional forms of biological and psychological treatment have been administered to children of military personnel at a federally-funded Florida psychiatric center, Dr. Morris Lipton of UNC-Chapel Hill testified July 23 before a Senate investigating committee.

Dr. Lipton, professor of psychiatry at the UNC School of Medicine and director of the Biological Sciences Research Center of the UNC Child Development Institute, said that electrical prods were used at Green Valley School, as well as "remote control electrified dog collars used in the training of dogs." This apparently was part of the Orlando, Fla. school's "behavior modification" program.

According to Dr. Lipton, the children had been fed from a kitchen too filthy to pass the Florida State Board of Health inspection, and they had been physically tortured—both through the choice of medical treatment and disciplinary measures.

Dr. Lipton was subpoenaed to testify before the Senate Permanent Subcommittee on Investigations after reviewing patient records, affidavits by nurses, one patient contract and reports written by the school's director, George Von Hilsheimer.

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Dr. Margaret Moore, director of the UNC Medical School's Division of Physical Therapy for 22 years, is stepping down as director to return to teaching. Under Dr. Moore's direction, the Division has attained a national reputation of excellence in clinical and educational areas. In addition to her duties as director, Dr. Moore was assistant dean for Allied Health Professions Programs in the School of Medicine from 1970 to 1973.

* * *

Dr. Clayton E. Wheeler, Jr., chairman of the Department of Dermatology at UNC School of Medicine, Chapel Hill, has been elected president of the Society for Investigative Dermatology.

The society, organized in 1937, has as its objectives, to "conduct, promote, encourage and assist investigation and research in medicine and surgery, and more particularly in dermatology and syphilology and allied subjects."

Dr. Wheeler is author or coauthor of more than 80 scientific articles or chapters in books. His major research interest has been herpes simplex (fever blister virus) infections and the relationship of the virus to host cells.

He is secretary-treasurer of the Association of Professors of Dermatology, member and director of the American Board of Dermatology and a member of the Council of the National Program for Dermatology.

Dr. Wheeler received his M.D. from the University of Wisconsin in 1941. He joined UNC as professor and chief of the Division of Dermatology in 1963, and in 1972 was appointed chairman of the Department of Dermatology.

* * *

At 41, Francoise Hall is discovering a new identity—one that, she says, "seems to fit better with the kind of person I am." The lithe, energetic mother of three has just completed her first year as a resident in psychiatry at the North Carolina Memorial Hospital in Chapel Hill.

Until last July she was an assistant professor of public health at Johns Hopkins University. She spent much of her time writing articles on population growth and editing a special edition of a medical journal on international population problems.

* * *

Dr. Philip R. Loe has been promoted to assistant professor in the Department of Physiology.

* * *

New faculty in the School of Medicine include the following:

Charles W. Carter, Jr., assistant professor, Departments of Anatomy and Biochemistry and Nutrition, is completing a year's postdoctoral fellowship at the MRC Laboratory for Molecular Biology at Cambridge University, England. A graduate of Yale University, he received his M.S. and Ph.D. at the University of California at San Diego.

Henry T. Frierson, Jr., assistant professor, Department of Family Medicine, completed his D.Ed. the

year at Michigan State University. He received his B.S. and M.Ed. from Wayne State University.

Stephen H. Gehlbach, assistant professor, Department of Pediatrics, is completing his M.P.H. at the University here this year. He holds the A.B. degree from Harvard and the M.D. from Case Western Reserve School of Medicine.

John C. Hisley, assistant professor, Department of Obstetrics and Gynecology, is chief of the High Risk Pregnancy Service and Ultrasonography at the University of Maryland Hospital. A graduate of Washington and Lee University, he received his M.D. degree from the University of Maryland.

Eng-Shang Huang, assistant professor, Departments of Medicine and Bacteriology and Immunology, has been a visiting assistant professor here for the past year. A native of Taiwan, he holds the B.S. and M.S. degrees from National Taiwan University and the Ph.D. from UNC-Chapel Hill.

Robert D. Stone, assistant professor, Department of Family Medicine, contingent upon completion of his Ph.D. from Michigan State University received his B.A. degree from Dennison University and his M.A. from Michigan State University.

New faculty in the UNC School of Nursing are:

Eleanor M. Brosning, assistant professor, received her B.S.N. from the Medical College of Virginia and M. S. from Boston University.

Cynthia Freund, assistant professor, received her B.S.N. from the University here and her B.S.N. from Marquette University.

Carol J. Gleit, assistant professor, completed her M.D. from North Carolina State University this year. She holds nursing degrees from the University of Wisconsin, Boston University and the University of Pittsburgh.

Vicky R. Hutter, assistant professor, School of Nursing, has been on the faculty of St. Petersburg Junior College for the past four years. She holds the B.S.N. from the University of Alabama and the M.S. from the University of Colorado.

Clara L. Milko, assistant professor, comes to Chapel Hill from the University of Texas School of Nursing. A graduate of St. Peters School of Nursing, she received her B.S. from the University of San Francisco and her M.S. and P.N.P. from the University of Colorado.

New faculty in the UNC School of Public Health include:

Donald L. Fox, assistant professor in the Department of Environmental Sciences and Engineering, has been a lecturer at UNC this year. He also was consultant with the Research Triangle Institute and the Environmental Protection Agency. He holds the B.S. from Wichita State University and the Ph.D. from Arizona State University.

Carol R. Hogue, assistant professor in the Department of Biostatistics, has served as a teaching assis-

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tant and research associate at the University here. She graduated from William Jewell College and received her M.P.H. and Ph.D. from UNC-Chapel Hill.

Mark D. Sobsey, assistant professor in the Department of Environmental Sciences and Engineering, is an assistant professor in the Department of Virology and Epidemiology at Baylor College of Medicine. His B.S. and M.S. are from the University of Pittsburgh and his Ph.D. from the University of California at Berkeley.

* * *

The Department of Health Administration, in UNC's School of Public Health in Chapel Hill announced the award of a \$300,000 Ford Foundation grant for continuation of its PopCase Project through 1977. The grant funds will be administered through the Carolina Population Center.

Established in 1971 with a \$250,000 Ford grant, the PopCase Project was the first organized attempt to develop training materials and management training programs in population/family planning program administration on a worldwide basis.

Director of the project is Dr. Sagar C. Jain, head of the Department of Health Administration and an associate director of the Carolina Population Center. Project codirectors are Dr. Curtis P. McLaughlin and Dr. James E. Allen.

* * *

Appointed to new assistant deanships in the School of Public Health are William T. Small, Jr., and Ernest Schoenfeld.

Small, former director of student and minority affairs, has been named assistant dean for student affairs. Ernest Schoenfeld is the new assistant dean for management and operations. He will continue as administrative director of the Occupational Health Studies Group.

* * *

Dr. Jerry Solon has received an \$18,389 six-month contract to do background work on nursing homes for the Health Resources Administration of the U.S. Department of HEW. Solon, visiting professor of health administration in the UNC School of Public Health, said that the background material will help the National Center for Health Statistics to analyze better its national survey data and guide its future surveys of nursing homes.

Richard M. Scheffler, assistant professor of economics at UNC-Chapel Hill was awarded \$149,850 from the Bureau of Health Resources Development in the Department of HEW to conduct nationwide surveys to estimate the optimal demand and supply of physician extenders.

* * *

Most of the 110 persons accepted for admission to the UNC Medical School this year are North Carolinians, according to Dr. William Straughn, director of the admissions committee. Only ten are from out of state.

The class is made up of 83 men and 27 women. Three of the entering medical students are American Indians, 21 are black and 86 are white.

THREE N. C. FOUNDATIONS FOCUS ATTENTION ON ACCESS TO CARE: FINANCIAL SUPPORT TO ENCOURAGE FULL-TIME EMERGENCY ROOM PHYSICIANS

Uneven distribution of health personnel and rising demands for health services are posing significant changes in patterns of delivery of health care, with resultant problems of access to health care by certain segments of the population.

Since November 1973, the trustees of the Duke Endowment, the Kate B. Reynolds Health Care Trust, and the Z. Smith Reynolds Foundation, in a desire to contribute to the solution of these problems have been cooperating in sponsoring and funding a study to determine how they might use some of their resources to assist in meeting some of North Carolina's most pressing health needs.

Upon his retirement, Mr. William F. Henderson, formerly Executive Secretary of the North Carolina Medical Care Commission, was retained by the three foundations to conduct the study. A panel of individuals active in various facets of the health care system in North Carolina was assembled for a three day conference to view the health care system and provide an opportunity for each participant to present his assessment from the viewpoint of his discipline.

This was supplemented by Mr. Henderson in interviews with representatives of disciplines not represented at the initial conference and with conversations with people at the grass roots level about their health delivery problems. The most recurrent theme of these investigations was the inaccessibility of medical services, particularly those that are required at night and on weekends and by people who are without the knowledge or the means to find the care they need when they need it. The problems are particularly crucial in rural and underprivileged areas.

The foundation Trustees have expressed a willingness to undertake a series of projects that hopefully will develop practical ways in which communities throughout the state can begin to make primary general illness health services more easily available to those who are having to do without them. An additional recurrent theme was that the community hospital and its organized medical staff are a natural and logical focal point in the provision of health services and have the potential for playing a wide role in the solution to problems of access to health care.

The North Carolina Hospital Education and Research Foundation proposed to utilize its established organization to assure continuity and cohesiveness of the effort. It will assist project applicants

and sponsors in the development of the projects. The three foundations have made grants to accomplish this purpose, as well as for implementation of projects deemed in accordance with the philosophy, purpose and resources of each foundation.

The proposal was to establish a program to maintain a continuing liaison with providers of health services in North Carolina, with the objective of (1) monitoring health needs, (2) identifying problems of access to health care, especially in rural and underprivileged areas, (3) developing practical approaches for responding to perceived health needs, and (4) identifying suitable sponsors to test proposed solutions.

The three foundations, with the encouragement of the North Carolina Hospital Association and the North Carolina Medical Society, wish to determine whether or not start-up assistance to a selected number of hospitals in supporting full-time physician coverage of emergency rooms is an effective way of getting at the access problem. It has been estimated that it might involve grants of up to \$600,000 initially to test the feasibility of this approach. Both the Kate B. Reynolds Health Care Trust and the Z. Smith Reynolds Foundation have made commitments toward this goal. The Duke Endowment is expected to provide financial assistance to individual hospitals as the program evolves and depending upon the

interest shown by hospitals and their organized medical staffs.

Hospitals which will test this approach will be selected in accordance with the procedure outlined below:

1. Recipient hospitals must be owned and/or operated by governmental subdivisions (state-owned facilities excluded) or community controlled, not for profit corporations.

2. Application grants must be jointly approved by each hospital's board of trustees and medical staff and submitted on forms to be provided.

3. Grants will apply only to full-time physician services and will usually be committed for more than one year.

4. Recipient hospitals would be expected to agree: (a) that during the initial visit to the emergency room, patients will not be denied attention even though their complaints may not be classified as urgent by emergency personnel; and, (b) to institute follow-through procedures whereby patients seen by the emergency physician will be aided in obtaining the additional care they may need.

5. Hospitals applying for grants will be selected in the following general manner: (a) if applications exceed available funds, only one hospital serving basically the same geographical area will be approved; (b) consideration will be guided by the extent of the

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applicant's community orientation and support, the comprehensiveness of its commitment to community health care, its prospective role in the state's emergency medical services plan and the availability of other emergency and ambulatory care program in the service area; and (c) hospitals with no full-time emergency physicians will be given first priority; then hospitals with existing contractual arrangements for part-time physician services proposing the use of

the grant to convert to full-time services; and other in descending order.

For information regarding projects that may be developed under this cooperative endeavor, contact Mr. William F. Henderson, Director, The Program on Access to Health Care, P. O. Box 12471 (50: Oberlin Road, Suite 237), Raleigh, N. C. 27605 (telephone: 919-832-5251).

Month in Washington

Congress's on-again-off-again attempt to write a national health insurance (NHI) law is very much off again—so far off that most observers believe there is no chance whatsoever for the 93rd Congress to go down in history as the author of mandated health insurance for all.

The method of financing NHI was again the stumbling block, cutting the House Ways and Means Committee down the middle in a 12 to 12 vote (a tie vote defeats an amendment) and thus scuttled a patchwork proposal by Chairman Mills that seemed to many likely to win Committee passage.

The dramatic tie vote came about the morning of Tuesday, August 20, after the Committee had been called to order by Chairman Mills with the admonishment, "We need to work awfully hard."

Staff began to explain the draft compromise, point by point, in routine fashion to the Committee when Rep. Joel T. Broyhill, (R-Va.) said he believed that the Committee should be given the opportunity to vote on alternate methods of financing NHI (as opposed to the Social Security payroll tax), such as the tax credit idea in the AMA Mediredit plan. Mills stalled Broyhill off until the financing section of the compromise regarding mandated employer coverage was completed. The Chairman was about to go on, when Broyhill again reminded Mills that he wanted a vote on his amendment. The AMA tax credit approach would be voluntary and consistent with the free enterprise system, according to Broyhill.

The first roll call vote of the Committee defeated the Broyhill proposal 11 to 10. One member, Rep. Bill Archer (R-Texas), changed his vote from "present" to "aye," and the motion was tied. Rep. Charles Chamberlain (R-Mich.), walked in and the proposal was ahead 12-11. However, Rep. Herman Schneebeli

(R-Pa.), showed up to cast a "no" vote and the tie 12-12 tally defeated the Broyhill proposal.

Though not apparent at the time, this was the beginning of the end. Rep. Omar Burleson (D-Texas) lost 13-12, on his bid to substitute the financing proposed by the health insurance industry's NHI plan. The crusher came at the afternoon session when the Committee approved 11 to 7 a motion to make voluntary, rather than mandatory, the compromise provision for the poor and the self-employed. This was a drastic setback for Mills who angrily adjourned the hearings until the next day.

The following morning shortly after the Committee had convened, Chairman Mills threw up his hands saying, "I've never tried harder on anything in my life. But we don't have it. I'm not going to go before the House with an NHI bill approved by any 13-12 vote." He said that the staff should try to figure out a different approach, but indicated that he believed chances of reaching a future agreement on NHI were dim.

The forced abandonment of his compromise plan was a bitter defeat for Mills and for the Administration, which had been working closely with the Chairman to steer a measure through the Committee. President Ford had urged Congress to give NHI top priority this year.

The up and down fortunes of NHI, which appeared to have a bright chance of passage following Ford's plea and Mills determined push for a compromise, have now slumped to the point that only some drastic intervention by President Ford could save the measure for this year.

Votes for the Mediredit financing plan came from Democratic Representatives Phil Landrum (Ga.) Richard Fulton (Tenn.), Omar Burleson (Texas) Sam Gibbons (Fla.), and Joe Waggoner (La.). Or

the GOP side, the pro-Medicaid votes were Representatives Broyhill (Va.), Jerry Pettis (Cal.), John Duncan (Tenn.), Donald Brozman (Colo.), Donald Clancy (Ohio), Bill Archer (Texas), and Charles Chamberlain (Mich.).

* * *

Self-employed physicians are about to receive some cheery news from Washington.

The House and Senate have passed and sent to the White House a liberalization of the Keogh law providing tax deferrals on retirement savings of self-employed people.

This means that physicians in this category can immediately start setting aside more money subject to tax deductions in qualified retirement programs. The bill's Keogh plan arrangement is retroactive to July 1, 1974.

There is no threat of a Presidential veto to cast any shadow on the legislation's becoming law.

The bill substantially boosts the savings subject to tax deductions. The present Keogh plan allows the self-employed to set aside, tax free, up to ten percent of their annual income with a \$2,500 a year maximum. The new law will allow 15 percent of earned income not to exceed \$7,500 a year.

House and Senate conferees, after months of work, finally agreed on all provisions of a sweeping pension reform bill that contains the Keogh provision. The measure had earlier swept through both House and Senate with only minor opposition to the Keogh provisions.

Organized labor had fought the liberalization as a loophole for wealthier people, but many of labor's staunchest backers, including Rep. Martha Griffiths (D-Mich.), disputed labor's stand and supported the provision.

The liberalization capped a long fight by the American Medical Association for tax treatment of the self-employed physicians that would give them the same tax incentives for retirement savings as are now present in most corporate pension plans.

The bill also contains a relatively minor restriction on corporation pension plans that would affect so-called professional corporations that have been gaining favor with many physicians in recent years because of the more attractive retirement tax treatment. Tax deferrals will not be allowed on savings that would exceed a pension that brings in more than 75 percent of highest earnings over a three-year period with a maximum potential retirement income of \$75,000 the limit. A "grandfather clause" exempts current plans that exceed this standard.

The new Keogh provisions and a new Keogh-type plan for the non-self-employed, not covered by company pensions, is expected to cost the government approximately \$500 million a year in lost revenues.

In urging approval of the plan, Rep. Al Ullman (D-Ore.), second-ranking Democrat on the House Ways and Means Committee, told the House, "What we have to do is to bring into balance as much

as we can the tax treatment for the self-employed as compared to the corporate community."

* * *

Less than half of the nation's physicians are now accepting assignment for all of their Medicare patients, according to the latest government figures. Deputy Assistant HEW Secretary Stuart Altman revealed the decline in testimony before the House Ways and Means Committee on national health insurance. HEW Secretary Caspar Weinberger later told the Committee that an NHI program should carry inducements for physicians to accept the assignment route, but opposed making it mandatory.

* * *

Retired military physicians may now accept positions as active physicians with the Defense Department without any loss of their retired pay. Defense hopes the exception to previous Civil Service Commission standards will induce retired military physicians to go to work for the Pentagon as civilian employees to help ease the shortage caused by the end of the military "doctor draft."

* * *

The Senate Labor and Education Committee has approved a revolutionary medical education bill that would require all medical graduates to serve in shortage areas and compel relicensing of all physicians.

The measure, written by the Health Subcommittee headed by Sen. Edward Kennedy (D-Mass.), carries almost \$1 billion in federal aid for medical and other health schools for the next five years.

In addition to the controversial mandatory service and relicensing provisions, the bill gives the federal government power to allocate and limit postgraduate training positions for physicians. Designed to curb reliance on foreign medical graduates and to increase the numbers of primary care physicians, the disputed provision also requires the Secretary of Health, Education and Welfare to limit the number of postgraduate physician training positions to no more than ten percent above the number of domestic medical and osteopathic school graduates that year. The HEW Secretary would assign the total number of certified positions established to the various categories of specialty and subspecialty practice of medicine.

The Association of American Medical Colleges and the AMA were sharply critical of these provisions. The legislation now before the House Health Subcommittee is not expected to contain them. Eventual fate may hinge on the outcome of a House-Senate conference.

* * *

The government issued final regulations defining the conditions under which Medicare will help pay for services provided by independent physical therapists and limited services by chiropractors.

Under the regulations, carrying out the Medicare amendments law of last year, covered chiropractic

services are limited to manual manipulation of the spine to correct "subluxations" which can be demonstrated by x-ray. Also, chiropractors must meet strict educational and professional requirements before their services can be reimbursed under the program.

The cost of x-ray will not be covered. HEW said the x-ray must demonstrate "at least . . . a malpositioning of a vertebra" identifiable by any experienced x-ray reader.

* * *

The American Medical Association has opposed legislation that would eliminate the authority of the Food and Drug Administration to control the kinds and amounts of ingredients in dietary supplements and other foods for dietary uses.

Appearing before the Senate Health Subcommittee, AMA officials noted that excessive use of vitamins can be harmful and is scientifically unwarranted. Combinations of vitamins should contain only those vitamins shown to be essential in human nutrition.

The witnesses were C. E. Butterworth, Jr., M.D., Chairman of the AMA's Council on Foods and Nutrition, and Vice Chairman Theodore Van Itallie, M.D. "There is no valid evidence to demonstrate that larger amounts of nutrients are beneficial under ordinary psychological conditions," said Dr. Butterworth.

Recent FDA regulations limiting the inclusions of certain vitamins or minerals, or both, in dietary supplements have aroused the wrath of food-vitamin

faddists and prompted introduction of legislation to overturn the FDA's actions.

Restriction of FDA's powers in this field, the AMA officials told the Subcommittee, "would permit an unchecked proliferation of health deception and economic fraud."

* * *

President Ford met with American Medical Association officials at the White House at the end of August. They discussed prospects for national health insurance in the current session of Congress and an AMA delegation's recent visit to China.

Those who attended the White House meeting included AMA President Malcolm Todd, M.D., Richard C. Palmer, M.D., Chairman of the Board of Trustees; Russell Roth, M.D., Immediate Past President; Max H. Parrott, M.D., President Elect; James Sammons, M.D., Executive Vice President Designate, and Joe Miller, Assistant Executive Vice President.

* * *

Correction: "Month In Washington" incorrectly reported (September) that the public utility type provision, defeated by an 8-1 vote by the House Health Subcommittee, covered both institutions' and physicians' fees. The Administration's Comprehensive Health Planning bill, which specifically called for regulation of fees of individual practitioners, was never seriously considered by the Subcommittee, according to a protest from Rep. William Roy, M.D., (D-Kan.).

Book Reviews

Current Medical Diagnosis and Treatment. Marcus A. Krupp, M.D., and Milton J. Chatton, M.D. (eds). 1,018 pages. Los Altos, California: Lange Medical Publications, 1974.

This is the thirteenth annual edition of this medical reference. The format has remained unchanged. All fields of internal medicine are concisely covered. Disorders are approached according to organ system, with special chapters on infectious disease, poisons, and malignant and immunologic disorders. The topics are discussed systematically according to the essentials of diagnosis, clinical findings, differential diagnosis, prevention and treatment. Although illustrations are few, there are numerous, clinically useful tables.

Finally, the index, perhaps the "heart" of any ref-

erence, is complete, listing symptoms, diseases and drugs.

Besides the standard and expected material, numerous topics, frequently omitted from more erudite publications, are included. The appendix includes recommendations for foreign travel and a practical guide to interpreting laboratory tests. The chapter on dermatology contains lists of numerous lotions, powders and ointments and their appropriate indications. In addition, disorders such as halitosis, discolored teeth and calluses are covered.

What is lacking in *Current Medical Diagnosis and Treatment* is that which is lacking in any publication which attempts to be concise and complete. Discussions are brief and must be considered as only introductions or refreshers. For instance, the recently re-

deased drug diazoxide receives only two short sentences. This shortcoming is partially compensated for by bibliographies which, in most sections, have been updated in this edition.

There are several other significant changes from the 1973 edition. The chapter on psychiatric disorders has been completely rewritten by a new contributor. The chapters on respiratory diseases, cardiac diseases, and gastrointestinal tract and malignant disorders now include discussions of immunologically mediated pulmonary diseases, the usefulness of echocardiography, the trifascicular cardiac conduction system, a more detailed classification and description of liver disorders, and the use of BCG as an immunostimulant. Additionally, the appendix, for the first time, contains a brief section on the problem-oriented record. Other chapters are unchanged or contain only minor revisions.

In their preface, the editors state that their intention is for this book "to serve the practicing physician as a useful desk reference . . . (and) not intended to be used as a textbook of medicine." With this caveat in mind, this reviewer recommends this volume to any prospective reader, or referrer, looking for an updated, comprehensive and concise view of medical diagnoses and treatment at a moderate price.

R. DURWOOD ALMKUIST, M.D.

Immediate Care for the Acutely Ill and Injured.

Hugh E. Stephenson, Jr., M.D. (ed.). 266 pages. Price, \$7.50. St. Louis, Missouri: C. V. Mosby Company, 1974.

With his continued interest in the care of the acutely ill and the injured patient, and with his teaching experience in this area, Dr. Stephenson has edited this book in a very orderly fashion. The authors of the various subjects and chapters have provided fundamental rationale for the immediate diagnosis and management of these patients. The subject matter is arranged in a systematic manner, and cross references to other chapters are provided. The index at the end of the book is easily utilized.

Because of the growing interest in emergency medicine, by hospitals and emergency trained personnel, and because the number of these facilities is rapidly increasing, more acutely ill or injured people are being seen for the first time in the emergency room. Dr. Stephenson's book is well timed. This publication should be in every emergency medical department and in the libraries of all people who are concerned with this type of practice—physicians, medical students, residents, and physician's assistants and emergency medical technicians who handle these patients. This book can be quickly and easily read. It is a matter of interest that *Immediate Care for the Acutely Ill and Injured* has no illustrations and no tables, especially noticeable in the chapter of

instruction on cardiopulmonary resuscitation. However, such material for the specific cardiopulmonary resuscitation can be readily sought in other manuals.

FREDERICK W. GLASS, M.D.

Selective Inhibitors of Viral Functions. W. A. Carter (ed.). 377 pages. Price: \$39.95. Cleveland, Ohio: CRC Press, The Chemical Rubber Company, 1973.

This book, one of the Monotopics Series published by the Chemical Rubber Company, includes 16 interesting and challenging articles written by 22 authoritative scientists who have made significant contributions in basic or applied research on antiviral agents. The articles cover new and relevant information on viral pathogenesis and antiviral drugs beyond the scope of any recent reviews; they are completed with an updated and comprehensive reference list.

The first article in the series is devoted to current concepts of viral pathogenesis at the molecular level, and is followed by two articles which cover specific approaches to viral chemo-prophylaxis and the current status of viral vaccines. The five articles on interferon give special emphasis to our understanding of the basic structural features of interferon, molecular requirements for interferon induction by viruses, nonviral agents or synthetic polynucleotides and the mode of action of interferon.

The last eight articles in the book present an in-depth coverage of current facts and speculations on known antiviral drugs, including amantadine (Symmetrel®), thiosemicarbazones (Marboran), arabinosyl nucleosides (ara-C), halogenated pyrimidines (iododeoxyuridine), guanidine and hydroxybenzylbenzimidazole (HBB), the anamycins (rifampin derivatives and streptovaricin) and the new synthetic analogs of viral genomes. Each of these comprehensive articles includes the antiviral spectrum of the drug, its mechanism of action, results of antiviral activity against infections in experimental animals and in man, the efficacy and toxicity data, and the drug's current promise as a clinically useful antiviral or anticancer agent. Emphasis is placed on correlating experimental data on the biochemical basis for antiviral or anticancer activity with clinical evaluation of the drug in determining whether the molecular action of the drug has potential as a therapeutic agent.

In summary, this book should be enlightening and rewarding to the molecular biologist, animal virologist, oncologist and chemotherapist. Although it has limited value to the physician faced with practical problems related to viral diseases, the book does present a full review of the researchers' efforts toward gaining a better understanding of the problems and of the current progress in finding useful drugs for treating human viral diseases.

LOUIS S. KUCERA, Ph.D.

In Memoriam

L. Nelson Bell, M.D.

Dr. L. Nelson Bell died on August 2, 1973, at the age of 79.

From 1941 to 1956 he was in surgical practice in Asheville, and for many years he was a medical missionary in China.

Following his retirement in 1956, Dr. Bell devoted full activity to the Presbyterian Church. He was an internationally known churchman, immediate past moderator of the Presbyterian Church, and former associate editor of the *Presbyterian Journal*.

A native of Virginia, he received his M.D. Degree from the Medical College of Virginia in 1916. He soon, thereafter, went to China where he was a member of the staff of Tsingkiangu General Hospital of 360 beds. He became chief surgeon in 1925, and superintendent in 1928. He continued in this capacity until 1941.

Dr. Bell had a distinguished career in medicine and was an important force in his church, serving in many outstanding positions. He was a fellow of the American College of Surgeons.

A man of remarkable capacity for achievement, Dr. Bell received many honors in his medical practice. He was a capable and devoted physician and will be sorely missed.

Surviving are his widow, the former Virginia Leftwich, four children, fifteen grandchildren and six great-grandchildren.

BUNCOMBE COUNTY MEDICAL SOCIETY

Cecil L. Crump, M.D.

Dr. Cecil L. Crump died on March 13, 1974, at the age of 68, after a long illness.

He had been in Eye, Ear, Nose, and Throat (EENT) practice in Asheville before serving as an officer in the United States Navy Medical Corps for four years. He was in private practice in ophthalmology in Asheville from 1946 until a few years before his death.

A native of Texas, Dr. Crump attended public schools in Fort Worth. He received his A.B. Degree from Texas Christian University and his M.D. Degree from Baylor. He did his postgraduate studies in ophthalmology at Wilmers Institute in Baltimore.

He was a staff member of Memorial Mission Hospital, Aston Park Hospital, and a consultant at Oteen Veterans Administration Hospital. He was a member of the Buncombe County Medical Society, the North Carolina State Medical Society, the American Medical Association and various EENT groups. He was also a member of the Christian Church.

A devoted physician, Dr. Crump will be missed by all who knew him. He is survived by his widow, Agnes L. Sparks Crump.

BUNCOMBE COUNTY MEDICAL SOCIETY

NORTH CAROLINA

Medical Journal

THIS ISSUE: Fiberoptic Bronchoscopy: An Improved Approach to the Diagnosis of Endobronchial Disease, Frederick A. Taylor, M.D., Felix A. Evangelist, M.D., and Jasper Phillips, M.D.; Psychopharmacological Treatment of Disorders of Senescence, William E. Fann, M.D., E. Jeanine Carver, and Bruce W. Richman; The Preoperative Localization of Hyperfunctioning Parathyroid Tissue Utilizing Parathyroid Hormone Radioimmunoassay of Plasma from Selectively Catheterized Parathyroid Veins, Samuel A. Wells, Jr., M.D., Irwin S. Johnsrude, M.D., George J. Ellis, M.D., John P. Bilezikian, M.D., Charles Johnson, M.D., William P. J. Peete, M.D., and Harry T. McPherson, M.D.

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orders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful



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Fiberoptic Bronchoscopy: An Improved Approach To the Diagnosis of Endobronchial Disease

Frederick H. Taylor, M.D., Felix A. Evangelist, M.D., and Jasper Phillips, M.D.

THE groundwork for the development of bronchoscopy may have been established by Green¹ in 1847. That year he described, before the Medical and Surgical Society of New York, a 19-year experience with intubation of the larynx by catheterization. He had become adept in catheterizations of the trachea and bronchi, but the Society condemned his claims as "an anatomical impossibility and unwarrantable innovation in practical medicine"² and requested him to withdraw from membership in the Society. The importance of his observation, however, was soon recognized. "Green's discovery, O'Dwyer's observations in connection with his discovery of the intubation tube and his invention of the incandescent electric light laid the foundation to the examination of the larynx and the endobronchial tree."³ Killian⁴ performed the first bronchoscopy in 1895. Illumination was by headlamp, and secretions were removed by sponging and sucking with a small pump designed by Killian. Two years later Killian re-

moved bone, from the right main stem bronchus with a bronchoscope.

In 1902 Einhorn⁴ described an auxiliary tube in the wall of an esophagoscope as a light carrier. This instrument was the beginning of the distally lighted bronchoscope.

In 1904, Ingalls⁴ reported the removal of two foreign bodies through a Killian tube. Jackson,⁵ in 1905, published his first report of the removal of foreign bodies through the bronchoscope. He described a bronchoscope with an obturator which he passed blindly using his left index finger as a guide, but he stated that Killian passed bronchoscopes without obturators using direct vision. Jackson also described the necessity for four assistants—one to watch respirations, one to watch the pulse, a primary assistant, and an unsterile assistant to turn on and off the electrical equipment.

The early endoscopists were concerned primarily with foreign body removal and cauterization of endobronchial lesions.^{2, 3, 5-7} The development of thoracic surgery gave increasing importance to the diagnostic value of bronchoscopy. Indeed, thoracic training programs can no longer be considered complete

unless the resident staff is taught to master bronchoscopy.

The combination of a straight tube with distal lighting, together with the later addition of angled telescopes, remained the basic principles of the bronchoscope for the next 60 years.

Various biopsy forceps were devised to collect bites of tissue which could be seen on direct vision. Bronchial washings and brushings⁸⁻¹³ made possible the collection of secretions from more distal areas for cytology, bacteriology and the study of particulate matter. These methods limited access to more peripheral areas.

The development of the flexible, fiberoptic bronchoscope by the Japanese in 1967 literally revolutionized bronchoscopy.^{14, 15} Improvement in visibility was made possible by the high intensity light and clarification of image by the lens system. The fiberoptic principle permitted accurate visibility around corners into upper lobe segments and all peripheral subsegments (Figure 1). The 5 mm diameter of the new scope permitted passage far into peripheral segmental and subsegmental bronchi. A small channel within the scope allowed secretion

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Fig. 1. Flexibility of the fiberoptic bronchoscope which has been inserted through a rigid bronchoscope, enabling easy access to the upper lobes.

collections from peripheral segments with suction. Small brushes on long, thin wires could be passed, under direct vision, far into the periphery to obtain brush biopsies for cytologic and bacteriologic smears.

TECHNIQUE

In this series all bronchoscopic examinations utilizing the flexible fiberoptic equipment have been done under local topical anesthesia using one percent Pontocaine®. Patients were premedicated with intramuscular injections of meridine hydrochloride (Demerol®) and sodium pentobarbital (Nembutal®). With the pa-

tient in the supine reverse Trendelenberg position and neck recumbent extended, a No. 8-40 standard Jackson bronchoscope was passed, in the usual fashion, into the upper trachea. The rigid scope was used as a conduit for the passage of the flexible fiberoptic bronchoscope, thus permitting the rapid removal and reinsertion of the flexible scope for lens cleaning or irrigation with saline. It also made possible the training of residents in passage of rigid bronchoscopes. The flexible scope was passed peripherally to visualize the distal trachea, carina, and right and left bronchial trees (Fig-

ures 2A-F). The excellent visibility and maneuverability of the flexible scope made possible the localization of segments which were bleeding, producing pus, or containing minute tumors or other lesions (Figures 3A-D). After visualization had been completed, selective washings were collected from the desired segment and appropriate brushings were taken for cell and bacterial studies (Figures 4A-B). If gross tumor was seen in a centrally located bronchus, the flexible scope was removed, the rigid scope advanced to the lesion, and a bite biopsy taken with the forceps. After both the rigid and flexible scopes were removed, the patient sat up to cough out the post-bronchoscopy sputum—often a diagnostic specimen.

ALTERNATE TECHNIQUES

Very rarely a rigid metal bronchoscope cannot be passed because the patient has severe cervical arthritis, temporomandibular joint malfunction, or the like. In such cases the flexible bronchoscope can be used. With the patient in the sitting or supine position and properly anesthetized topically, the flexible scope can be passed through a nostril down the trachea and out into the bronchial tree for inspection and collections of secretions and brushings. A few drops of phenylephrine hydrochloride (Neo-Synephrine®) in the nostril may be necessary to produce an adequate nasal lumen. A nasopharyngeal tube is recommended by Wanner^{16, 17} as a conduit for the fiberoptic bronchoscope.

The transnasal technique has several disadvantages. It can be complicated by laryngospasm, particularly if no hollow conduit is used to pass the scope. This technique does not allow for free and easy withdrawal and reinsertion of the flexible scope for cleansing between selective brushings and washings from different areas. Residents do not learn the techniques for rigid bronchoscopy. Small nostrils can cause damage to the flexible bronchoscope.

The passage of an endotracheal tube makes a good conduit for the flexible scope, but large bite biopsies cannot be taken, as when the rigid



Fig. 2A



Fig. 2B



Fig. 2C

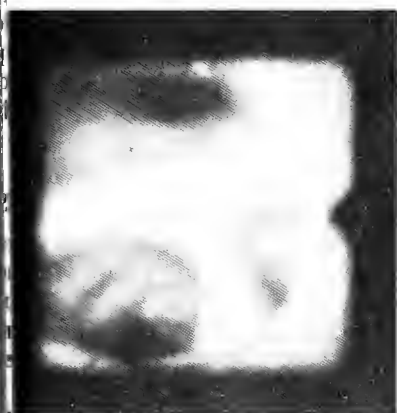


Fig. 2D

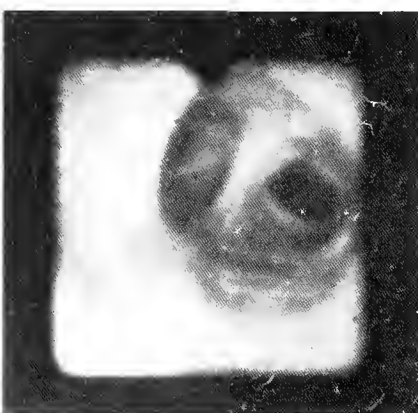


Fig. 2E

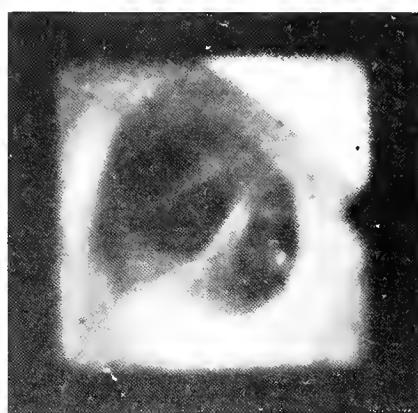


Fig. 2F

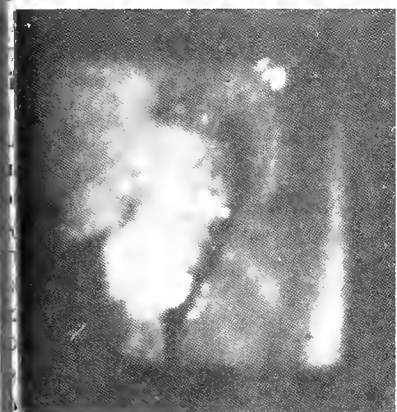


Fig. 3A



Fig. 3B

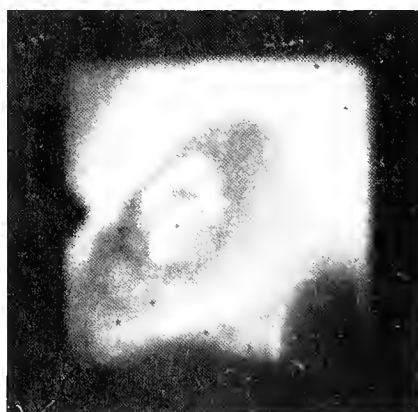


Fig. 3C

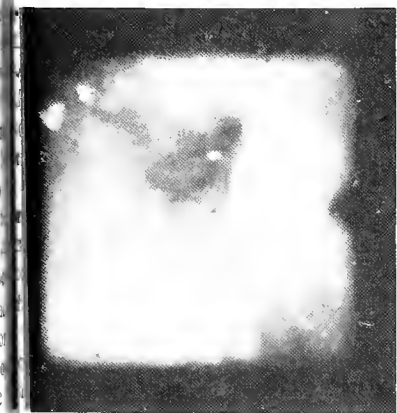


Fig. 2. Fiberoptic views of peripheral bronchi: A. Left upper lobe and segmental bronchi. B. Anterior segment and subsegments of the left upper lobe. C. Left lower lobe and basilar segments. D. Right upper lobe and its three segmental bronchi. E. Right middle lobe and two segmental bronchi. F. Right lower lobe and basilar bronchi.

Fig. 3. Visualization of peripheral bronchogenic carcinoma through the flexible bronchoscope. A. Tumor in anterior segment left upper lobe. B. Ulcerating cancer in subsegments of left upper lobe. C. Small polypoid carcinoma in anterior segment of left upper lobe. D. Carcinoma producing stenosis of right upper lobe bronchus.

Fig. 3D



Fig. 4A



Fig. 4B

Fig. 4. A. Chest x-ray showing biopsy brush passed through flexible bronchoscope into a small carcinoma in periphery of left upper lobe. B. Bronchoscopic view of brush.

bronchoscope is used. However, newer flexible scopes do allow for tiny bite biopsies.

Patients with tracheostomy tubes in place are easily examined with the fiberoptic bronchoscope (Figure 5). A few drops of local anesthetic instilled through the tracheostomy tube permits passage of the bronchoscope. The flexible scope will go through No. 5 or larger tracheostomy tubes, and it is useful for evaluating the tracheal mucosa of patients with long-term tracheostomy tubes.¹²

LIMITATIONS

The flexible fiberoptic broncho-

scope is not yet useful for the removal of foreign bodies, nor can it be used in small children. Thick secretions and blood are difficult to aspirate rapidly through the small suction channel. Sterilization of this instrument is a problem; cleansing with Betadine is most often used, but gas sterilization is necessary at times and takes several hours. The flexible bronchoscopes are expensive and it is not practical to own several instruments.

Some writers have advocated the use of the flexible bronchoscope at the patient's bedside for diagnoses and for removal of thick secretions and correction of atelectasis.¹⁶⁻¹⁷⁻¹⁹

We do not advocate this approach routinely since complications, although rare, arise which necessitate emergency measures — that is, in such instances as laryngospasm (especially when the flexible scope is passed through the nose), reactions to local anesthetic, and severe endobronchial bleeding. Postoperative patients with thick secretions should rarely require bronchoscopy if they are managed well with early ambulation, assisted coughing and tracheal suction. If secretions are too thick to be managed in this way, then the rigid bronchoscope with large bore suction cannulae are preferred. It would seem that the flexible bronchoscope is too fine and expensive an instrument to use routinely for maintaining good bronchial cleansing when more simple means are available. As we mentioned previously, the small calibre of the suction channel in the flexible scope does not allow effective removal of thick secretions.

EXPERIENCE

The present report is based on 727 bronchoscopic examination done over the past two and one-half years in three hospitals. One hundred eighty-nine (26 percent) of these patients had either or both histologically and cytologically proven primary bronchogenic carcinoma. The remaining patients had a variety of diagnoses including bronchitis, unresolved pneumonia, adenoma



Fig. 5. Fiberoptic bronchoscope passed through a tracheotomy tube.

metastatic cancer, lymphoma, sarcoma, tuberculosis and "hemoptysis of undetermined etiology."

Of the 189 cases of primary lung cancer, the lesion was seen through the rigid bronchoscope in 58 cases (30.7 percent.) The flexible fiberoptic bronchoscope permitted visualization of this tumor in an additional 62 cases (33 percent); tumor visibility more than doubled (63.7 percent) with the flexible scope. The combination of brush biopsies, bite biopsies, bronchial washings and postbronchoscopic sputum examinations yielded a diagnosis of cancer in 88, 61, and 52 percent of patients with primary bronchogenic carcinoma in three hospitals. These figures increased to 76, 76, and 63 percent when the highly questionable specimens were added to the positive specimens. Absolute negative studies were found in 5, 24, and 37 percent in these three hospitals. There were no false positive reports in this series.

DISCUSSION

The improvement in tumor visibility and diagnosis with the flexible

bronchoscope has made possible early surgery for more patients with cancer and has determined inoperability in others. In three patients who had hemoptysis and cancer cells in their sputum but negative chest roentgenograms and negative gross bronchoscopic findings, tumors were properly localized by selective five-lobe brush biopsies and washings. These patients had negative findings at the operating table, but the proper lobe was resected in each case. Three patients with apparently operable unilateral cancer as determined by roentgenogram studies were declared inoperable. Using the flexible scope in each of these cases, an unsuspected second primary cancer was found in the contralateral lung.

In a few cases a primary bronchogenic carcinoma was detected by brush biopsies under direct vision, but the cytologist was unable to make a diagnosis of cancer from the smears. Despite those occasional unexplainable cases, the ability to obtain brush biopsies from a tumor under direct vision has usually produced a positive diagnosis. Flexible fiberoptic bronchoscopy has been a

very gratifying addition to our diagnostic approach to endobronchial disease. It is hoped that instruments will be developed for use in small children in the near future. The flexible fiberoptic bronchoscope has not yet abolished the need for the older rigid bronchoscope.

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Psychopharmacological Treatment of Disorders of Senescence

William E. Fann, M.D.,* Jeanine C. Wheless,† and Bruce W. Richman‡

PSYCHOPHARMACOLOGICAL treatment of disorders of senescence has traditionally focused on impairment of brain tissue function. Even when the elderly have predominantly depressive or paranoid symptoms, these symptoms are frequently assumed to be merely prodromal to the emergence of an underlying cerebral disease, and the possibility of psychoses, other than those related to senility or arteriosclerosis, is excluded. However, chronic brain syndrome is not always the predominating mental illness of the elderly; functional psychoses, confusion and neuroses are also common. Often, improvement after the use of psychopharmacological agents is due to the effects of the medications upon the latter categories of illnesses, occurring separately or concurrently with chronic brain syndrome, rather than

to any actual alteration of brain function.¹⁻³

Emotional decompensation might accompany the progressive loss of intellectual function in the senium. Hence, the senile are a group of people who are at special risk for the development of other psychiatric disorders. Frequently, however, co-existent anxiety, depression or psychosis goes undiagnosed and untreated. Psychotropic agents used in the treatment of mental disorders accompanying chronic brain syndrome, either coincidentally or secondarily, are substantially those prescribed for younger patients. However, these drugs must be administered on a modified basis to aged, intellectually debilitated people.

Pharmacological intervention in the senile dementing process has not succeeded in reversing the syndrome, but some tentative efforts have mitigated symptomatic intensity. Stimulant compounds, vasodilators, hormones, vitamins, anticoagulants, nootropic agents, and "rejuvenating" drugs have received clinical trials, with varying degrees of success, in reducing some individual components of chronic brain syndrome. Some of the benefits and detriments of these drug classes will

be reviewed as applied to psychiatric syndromes in the elderly.

CHRONIC BRAIN SYNDROME

Chronic brain syndrome is characterized by a history of gradual intellectual and personality disorganization for a period of several months to several years; disturbances in intellectual functions involving comprehension, memory and orientation; disturbances of affect — emotional instability, irritability, anxiety, apathy; and delusions or hallucinations.⁴ Senile psychosis and arteriosclerotic psychosis are the two forms of organic brain syndrome.

Senile psychosis is indicated "by a history of gradual and progressive failure in general efficiency in everyday life dominated by changes in the intellect, memory, and personality in the absence of specific etiological factors. . . ."⁵ Although the cause of the condition is not known, metabolic, endocrine and vascular factors have been implicated, and there may be genetic determinants.⁶ Onset usually occurs in the seventh to ninth decades and is more common in women than men. Although senile psychosis is similar to normal aging in many respects, senile dementia brings about a more profound and rapid deterioration and

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gher mortality. The pathological changes in senile psychosis are diffuse, resulting in a complete disorganization and degradation of behavior.^{5,6}

Arteriosclerotic psychosis is dementia associated with focal indications of cerebrovascular disease. It develops more rapidly than senile psychosis, fluctuates in severity, and is usually accompanied by emotional incontinence or epileptiform seizures, or both. Insight is usually intact.¹ A general effect of arteriosclerotic psychosis is the destruction of the more complex and subtle features of personality, although judgments based on experience and more intact personality traits remain relatively intact.⁶

Many investigators claim that cerebral blood flow diminishes with aging. This proposition is apparently true in cases of cerebral arteriosclerosis, and perhaps in senile dementia, since a diminished oxygen consumption is associated with decreased metabolic demands. By improving cerebral blood flow, hypoxic degeneration and death of neurons might be prevented, and the functional capacity of still unaffected neurons could be increased. The use of vasodilators has been the most common therapeutic approach for improving cerebral blood flow.⁷ Vasodilators include nitrites, nicotine acid or its congener, and papaverine. To date, no convincing evidence that these agents improve blood flow or mental functioning has been published. Additionally, some danger exists in the use of vasodilator compounds, in that induction of a generalized cerebrovascular dilatation might redistribute blood flow to the detriment of more compromised areas.⁸

Other agents used for increasing cerebral blood flow, and thus for improving mental functioning in the elderly, are anticoagulants. Walsh⁹ (1969) studied the use of bishydroxycoumarin in patients having chronic brain syndrome. These patients showed major improvements, such as regaining lost bladder and bowel control. Ratner et al⁷ (1972) conducted a study of warfarin prescribed for patients afflicted with

senile dementing processes. The anticoagulant group of subjects underwent less mental deterioration than the control group, although there was no significant difference. Both studies stressed the importance of selecting patients who have early symptoms of organic brain syndrome.

A recently proposed method of increasing blood flow in patients having senile dementia is hyperoxygenation in which hyperbaric oxygen is used.⁷ Jacobs et al¹⁰ (1969) concluded that memory and conceptual ineffectiveness in senile patients were improved by intermittent hyperoxygenation.

However, Dastur et al¹¹ have shown that the cerebral blood flow of a 70-year-old patient is no different from that of a 20-year-old patient when arteriosclerosis is not present. Even in persons having significantly reduced cerebral flow, powers of memory for distant events, abstract reasoning, arithmetical and intellectual skills, and appropriateness of emotional response remain largely intact. Cerebral tissue continues to metabolize actively regardless of reduced cerebral flow. Utilization of oxygen (CMRO₂) was not significantly reduced in subjects having arteriosclerosis; only in institutionalized senile psychotic patients was the CMRO₂ finally significantly reduced. The findings of Dastur et al¹¹ suggest that, with age, the primary change in the central nervous system is a diminution of cerebral circulation, after which there is a reduction of metabolic function accompanied by a decline in mentation.

Although they might have a beneficial effect in the chronically malnourished elderly, routinely administered hormones and vitamins for the treatment of senility in an adequately nourished person have not been demonstrably efficacious. Hormone replacement therapy, indicated in hypothyroidism or Addison's disease, might result in the return of the patient's general systemic status to normal and thereby contribute to an overall improvement in his state of health. However, specific hormones for reducing the

psychiatric symptoms of senility have not proven effective. There is little indication that megavitamin therapy, which has been ineffective in the treatment of psychoses in other age groups, would relieve the symptoms of senility.¹² However, a recent study of megavitamin therapy by Altman et al¹³ (1973) produced significant results. Twelve patients having chronic brain syndrome resulting from arteriosclerosis demonstrated a dramatic and unexpected decrease in Excitement Scale scores after treatment with the multivitamin "Allbee with C"; they improved sufficiently to be sent home. The authors did not know why the method was successful, but they postulated that the combination of vitamins might have had a potentiating or additive effect.

Stimulant compounds (Table 1) include amphetamine and its congeners, such as methylphenidate. These agents sometimes are efficacious in the apathetic, hypoactive senile patient, but they cannot be recommended for long-term therapy because of their pressor effects on the fragile and partially decompensated cardiovascular systems of the elderly. Because they have a high potential for causing dependency, stimulants should be administered to the elderly in low doses (5 to 10 mg amphetamine per day) for a very brief period (one to seven days). The therapeutic value of the stimulants appears to be quite limited, and they certainly cannot rejuvenate function of brain tissue lost through the attrition of age.

Nootropic agents are a recently established class.¹⁴ These compounds supposedly increase neuronal cellular repair and intraneuronal protein synthesis, thereby activating, protecting and restoring the working of the impaired nerve cells while improving the function of healthy neurons. Their supposed preferential activity is situated at the cortical levels. Most reports of successful clinical trials of these compounds have been published in Europe.

The most widely publicized and tested "rejuvenating" drug has been Gerovital H₃, a specially formulated

Table 1
Stimulants

Nonproprietary Name	U.S. Trade Name	Total Daily Dosage (mg) Outpatient (Range)	Hospital (Range)
dextroamphetamine sulfate	Dexedrine	15-30	30-60
methamphetamine hydrochloride	Desoxyn, Methedrine	2.5-5	15-30
methylphenidate hydrochloride	Ritalin	10-30	30-60
piradrol	Meratran	2-4	4-10

preparation of procaine hydrochloride. According to reports of Anna Aslan of Rumania, who originated the drug, H₂ has "anabolic" and general "eutrophic" effects, revitalizes tissue, leads to a more active life for geriatric patients and restores physical and intellectual ability.¹⁵ Studies have shown H₂ to be an effective monoamine oxidase inhibitor which seems to have selective affinity for certain multiple forms of MAO. Since depression in the aged and the process of aging itself are correlated with high MAO activity,¹⁶ the beneficial results of the preparation might be a result of its inhibition of MAO. Other clinical studies with H₂ have demonstrated a beneficial effect on skin tone and turgor, stabilization of blood pressure in hypertension, alleviation of depression and psychotic symptoms, and improvement in symptoms of senility.¹⁵ Using the precise clinical regimen dictated by Dr. Aslan, Friedman¹⁷ (1964) prescribed Gerovital H₂ to twelve patients suffering from chronic brain syndrome. Four of these patients showed good improvement, primarily in relief of senile confusion; the remaining eight patients showed mild to minimal improvement. With discontinuance of therapy, the improved group relapsed to pretreatment condition. Reinstitution of therapy again yielded improvement.

AFFECTIVE DISORDERS

Depression in the elderly is often precipitated by disruptive personal events such as physical illness, bereavement or retirement.^{6, 18} However, many elderly people have had depressive episodes throughout life, and the symptoms of senescence are added to those of depression. As depression increases, symptoms of sadness and dejection, slowing of intel-

lectual processes, and psychomotor retardation become more apparent. Frequently, the patient complains of loss of appetite, insomnia and increased fatigability.⁴ If depression is severe enough to cause memory disturbance, it may be difficult to differentiate between the depression and a chronic organic state; or when the condition leads to self-neglect and disturbed behavior, or marked retardation, it might be difficult to differentiate between depression and dementia.¹⁸ Not infrequently, moderate to severe depression with minimal organic brain disease may be misdiagnosed as chronic brain syndrome associated with cerebral arteriosclerosis or senile brain disease.³ Generally, however, functional depression appears abruptly, whereas depression secondary to brain damage tends to appear gradually, with mild, early symptoms, and to fluctuate, usually disappearing as the effects of brain disease become more pronounced and dementia supervenes.⁶

Classical psychiatry taught that affective disturbances were early manifestations of impending senile or arteriosclerotic psychosis.¹ Al-

though disorientation, memory loss and impairment of intellectual function and judgment are considered primary characteristics of organic brain syndrome, the possibility of other psychoses or neuroses should not be excluded,¹⁹ and treatment should be expeditiously instated.

Psychopharmacological treatment of patients having psychiatric illnesses is most often effective in the area of the major depressions.³ Drug therapy is essentially that used with younger patients, except that starting doses should be lower and the patient should be carefully monitored for the occurrence of side effects. The drugs most commonly employed in the treatment of depression are the tricyclic antidepressants and monoamine oxidase inhibitors (Table 2). The tricyclics include sedative and nonsedative agents, the former types being indicated for agitated, restless elderly people; the latter are used for retarded depression in which hypoactivity and hypomertation secondary to the affective disorder are target problems. These medications are most efficacious in mild to moderate depression, and the long time lag (two to four weeks) in the onset of therapeutic action of tricyclics can be a contra-indication when depression is unusually pronounced. Atropine-like and antiadrenergic actions of tricyclic antidepressants can produce unpleasant and dangerous side effects in the elderly.²¹

A recent study by Libow²² (1973) confirmed a previous report by

Table 2
Antidepressant Drugs
(Mood Active Agents; Mood Elevators)

Nonproprietary Name	U.S. Trade Name	Total Daily Dosage (mg) Outpatient (Range)	Hospital (Range)
Tricyclic Derivatives:			
amitriptyline hydrochloride	Elavil	50-150	74-225
desipramine hydrochloride	Norpramin, Pertofrane	75-150	75-200
imipramine hydrochloride	Tofranil	50-150	75-225
nortriptyline hydrochloride	Aventyl	20-100	40-100
protriptyline hydrochloride	Vivactil	10-40	15-60
Hydrazide MAO Inhibitors:			
isocarboxazid	Marplan	10-30	10-50
nialamide	Niamid	25-75	100-450
phenelzine sulfate	Nardil	15-30	15-75
Non-Hydrazide MAO Inhibitors:			
tranylcypromine sulfate	Parnate	20-30	20-30

Streese et al²² regarding enhancement of antidepressant action by adding triiodothyronine (T₃) to a daily tricyclic dose. The mechanism of action may be in an increase in the level of biogenic amines in the central nervous system. A decrease in thyroid hormone leads to an increase in MAO in the brain. This is postulated to be related to depression since a decrease in MAO is antidepressant. Thus, the administration of thyroid may inhibit MAO and lead to an increase of biogenic amines in the central nervous system.²

Monoamine oxidase inhibitors are used less frequently because they potentiate pressor amines and are inherently toxic.²³ These agents also potentiate the action of numerous unrelated drugs (anesthetics, barbiturates, adrenal corticosteroids, ganglion-blocking agents, morphine, propine, and 4-amino-quinoline compounds); diuretics potentiate the antidepressive and hypotensive effects of MAO inhibitors.³ However, Nies et al¹⁶ have shown an age-related increase in brain monoamine oxidase enzyme levels, indicating possibly the efficacious application of MAO inhibitors in cases of geriatric depression.

Stimulant compounds (Table 1) have also been tried as antidepressants. However, their beneficial effects upon the patient's mood offset rapidly, they have potent pressor effects, and there is a high risk of the patient's developing drug tolerance or dependency. The effectiveness of the stimulants in the elderly is questionable, and although stimulants may be of adjunctive value with other agents, they are not recommended for use as antidepressants. When depression imposed on senility has reached psychotic proportions, electroconvulsive therapy might be indicated.²⁴

Delirium, or acute confusional state, usually occurs during the course of chronic brain syndrome.⁴ However, acute and potentially reversible mental change occurs frequently among the elderly and is often misdiagnosed or overlooked.² It is often difficult to differentiate these transient confusional states from those associated with senile or

arteriosclerotic psychosis.⁶ Acute confusional states are nearly always associated with physical illness or drug intoxication; antiparkinson agents, tricyclics, digitalis and phenobarbitone are especially liable to cause delirium. The patient usually has a history of sudden onset of mental impairment and recent medical or surgical illness or change in drug therapy. Complaints of increased restlessness, toward the end of the day or at night, and visual perceptual disturbances are common.¹⁸

PSYCHOSIS

Late paraphrenia is a form of schizophrenia, occurring late in life, in which the patient exhibits a system of well-organized paranoid delusions, accompanied by an intact personality.¹ Factors which tend to contribute to the development of paranoid reactions at any age (social isolation, solitary living, general insecurity, and sensory defects, particularly visual and hearing loss) tend to be more frequent in old age.²⁰ However, senile degeneration or cerebral arteriosclerosis, when it occurs in a person with a pronounced "schizoid" disposition, might result in late paraphrenia.⁶ Unless the paranoid reaction is a

component of depression, antipsychotic medications are preferable.

Antipsychotic agents (Table 3) include the phenothiazines, thioxanthenes, butyrophenones, rauwolfia alkaloids, and the lithium ion. The most commonly used are the phenothiazines. Phenothiazines are prescribed for the agitated, delusional, hallucinating senile patient and they are often effective in reducing the symptomatic intensity of a core psychotic process. Common dose ranges of chlorpromazine (Thorazine®), the principal phenothiazine, are 200 to 800 mg per day. In a recent study, thiothixene, a thioxanthene, produced notable improvement in psychiatrists' and nurses' rating scales and global assessment of 26 patients having senile or arteriosclerotic psychosis. Side effects did not interfere with treatment.²⁵ However, the patient who is over 65 years of age has a greatly reduced ability to metabolize, and hence to tolerate the antipsychotic medications. The physician should initiate therapy at lower doses than he would ordinarily prescribe for a younger patient, and he should be particularly alert to the incidence of side effects, especially those associated with the atropine-

Table 3
Antipsychotic Agents
(Neuroleptics; Major Tranquilizers)

Nonproprietary Name	U.S. Trade Name	Total Daily Dosage (mg) Outpatient (Range)	Hospital (Range)
Phenothiazines—classified by side chain:			
Aliphatic:			
chlorpromazine	Thorazine	50-400	200-1,600
trifluorpromazine hydrochloride	Vesprin	50-150	75-200
Piperidine:			
thioridazine	Mellaril	50-400	200-800
mesoridazine	Serentil	25-200	50-400
Piperazine:			
acetophenazine maleate	Tindal	40-60	60-80
carphenazine	Prokettazine	25-100	50-400
prochlorperazine	Compazine	15-60	30-150
thiopropazate dihydrochloride	Dartal	10-30	30-150
perphenazine	Trilafon	8-24	12-64
trifluoperazine	Stelazine	4-10	6-30
fluphenazine hydrochloride	Prolixin, Permitil	1-3	2-20
butaperazine maleate	Repoise	10-30	10-100
piperacetazine	Quide	10-40	20-160
Butyrophenones:			
haloperidol	Haldol	2-6	4-15
Thioxanthene Derivatives:			
chlorprothixene	Taractan	30-60	75-600
thiothixene	Navane	6-15	10-60

like and antiadrenergic properties of these agents. Possible side effects include dry mouth, urinary retention, constipation, nasal congestion, aggravation of glaucoma, drowsiness, lethargy, hypotension and extrapyramidal symptoms.³ Because geriatric patients have a special susceptibility to phenothiazine-induced states of confusion and delirium, these states can be mistaken by the physician for an increase in the intensity of psychiatric symptoms; as a result, the physician might increase the dosage of the offending agent.

ANXIETY REACTIONS

Intellectual and emotional malfunctioning of senescence contributes to emotional problems. The elderly must adapt to new and essentially unfavorable life circumstances at a time when their ability to adapt is greatly diminished. Additionally, old age can bring out latent neurotic conditions, or it might aggravate existing neuroses.⁶ Anxiety is common in the elderly.

Antianxiety agents (Table 4) can be sedatives, muscle relaxants or anticonvulsants. The group includes a broad range of chemically heterogeneous compounds which have similar clinical effects. Ethanol, barbiturates, meprobamate, the benzodiazepines such as chlordiazepoxide, diazepam, oxazepam, and even paraldehyde and hydroxazine, are all classed as anxiolytics. These clinically effective compounds are indicated for allaying anxiety and reducing its unpleasant somatic components. Chlordiazepoxide (Librium®), because it is comparatively safe, is generally recommended for treatment of anxiety in the elderly, although idiosyncratic adverse responses are possible. The elderly can develop dependency upon antianxiety agents, and side effects such as glaucoma are associated with some of the compounds. Withdrawal symptoms, after treatment with prolonged heavy dosages of these agents, can be mistaken for the onset of psychosis in elderly patient; such a misconception can be particularly damaging.

Rauwolfia alkaloids appear to be of some value in treating symptoms of anxiety, agitation and inappro-

priate aggressiveness in the elderly; these antianxiety agents are particularly useful when a lowering of blood pressure or pulse rate is desirable. However, when taken orally, there is a delay in onset of action; occasionally an initial period of excitement precedes improvement; the convulsive threshold is lowered; there is a possibility of gastrointestinal bleeding; and the increased gastrointestinal activity may be detrimental to patients with peptic ulcer and ulcerative colitis.³

SUMMARY

A predisposition toward the diagnosis of senility in psychiatrically compromised geriatric patients may prejudice accurate assessment and treatment within this population. Geriatrics may present with the entire range of psychopathological symptoms, in either the absence or presence of actual senile symptomatology. Vasodilators have been used in the pharmacological treatment of the senile disease processes, but no positive results have been published to date. The anticoagulants, bishydroxycoumarin and warfarin, are reported to have been successful in mitigating some senile symptoms when patients were diagnosed soon after onset of the pathological condition. Memory and conceptualization in the senile were reported to be improved by intermittently using hyperbaric oxygenation. Hormones and vitamins are not generally efficacious in the treatment of senility, although one investigator has obtained positive results in some

Table 4
Antianxiety Drugs
(Minor Tranquilizers)

Nonproprietary Name	U.S. Trade Name	Total Daily Dosage (mg) (divided into 2-4 doses)
Glycerol Derivatives:		
meprobamate	Equanil, Miltown	800-3,200
phenaglycodol	Ultram, Acalo	600-1,200
tybamate	Solacen, Tybatran	750-3,000
Benzodiazepine Derivatives:		
chlordiazepoxide hydrochloride	Librium	15-300
diazepam	Valium	5-60
oxazepam	Serax	30-120
Diphenylmethane Derivatives:		
hydroxyzine hydrochloride	Atarax, Vistaril	75-400
Barbiturates:		
phenobarbital		30-300

parameters with megavitamin therapy.¹³ Stimulant compounds have not effectively mitigated senile symptomatology. Nootropic agents, a recently established class, and rejuvenators, such as Gerovital H₃, which bears resemblances to the MAO inhibitors, are currently undergoing trial, with some preliminary reports registering positive results in alleviating senile confusion. Thiothixene, a major tranquilizer of the thioxanthene class, is reported to have brought about notable improvement in patients with senile or arteriosclerotic psychosis.

Affective disorders occurring in the elderly can accompany senescence and might be mistaken for a nonexistent senile state. Depressions in the aged are most commonly treated with tricyclic antidepressants, monoamine oxidase inhibitors, and, when psychosis is apparent, with electroconvulsive therapy. Delirium and paraphrenia frequently accompany chronic brain syndromes.

Delirium is usually secondary to illness, or it is drug induced and should be treated accordingly. In cases of paraphrenia, antipsychotic medication is of benefit unless contraindicated. Since geriatric patients are particularly susceptible to the possible side effects of these drugs, the antipsychotic medication should be administered only when professional observation or consultation can be arranged. Anxiety concomitant to senility can be treated with the usual battery of anxiolytics, of which chlordiazepoxide (Lib-

im®) is generally the safest effective agent. Dependency upon anti-aging agents by the elderly is possible and should be guarded against. Psychotropic agents can be useful in treating the senile patient, but administration of these compounds must be modified to accommodate the reduced abilities of the elderly to metabolize and withstand the side effects.

Acknowledgment

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It has been thought possible to find a more exact criterion in the pulsation of the heart. The *cor ultimum moriens* has been regarded as the rule since the time of Galen; physiologists have agreed upon it. In their laboratories stoppage of the heart is looked on as the end of life; as soon as the heart of an animal that is being experimented upon ceases to beat, physiologists admit that the animal is dead.

Can we accept this criterion in forensic medicine? I do not think so. In certain medico-legal cases, the value of the sign may be disputed; the judge may ask you to say at what precise moment death took place, and that for several reasons.—*Death and Sudden Death*, P. Brouardel, 1897, p. 18.

The Preoperative Localization of Hyperfunctioning Parathyroid Tissue Utilizing Parathyroid Hormone Radioimmunoassay of Plasma From Selectively Catheterized Thyroid Veins

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OVER the past several months we have studied ten hyperparathyroid patients preoperatively, attempting to localize their lesions by measuring parathyroid hormone (PTH) in plasma from selectively catheterized thyroid veins. In two patients, selective superior and inferior thyroid arteriography was also performed.

This described technique is specific in that it gives an objective measurement of parathyroid hypersecretion. By contrast, the previously reported localization methods such as ¹²⁵selenomethionine scanning,¹ thermography,² arteriography,³ venography⁴ and cine-esophagography⁵ are nonspecific in that both parathyroid and thyroid lesions give positive results. Furthermore, these latter methods usually detect only the large parathyroid neoplasms which would have been relatively easy to identify at surgery without localization aids.

MATERIALS AND METHODS

Patient population: Nine patients with primary hyperparathyroidism

and one patient with tertiary hyperparathyroidism were admitted to the inpatient service of the Department of Medicine or Surgery at the Duke University Medical Center or the Durham Veterans Administration Hospital. There were five men and five women ranging in age from 39 to 67 years. Six of the ten patients had undergone prior surgical exploration for hyperparathyroidism, and the lesion(s) had been either missed or incompletely resected. The diagnosis of primary hyperparathyroidism was established in each patient by clinical, biochemical, and in some cases, radiological criteria. The patients are listed in Table 1.

Venous catheterization procedure

All ten patients underwent selective venous catheterization as described previously.^{6,7} Under local anesthesia the Muller guided catheter (U.S. Catheter and Instrument Corporation) was introduced percutaneously into a femoral vein. A 100 cm flexible guide wire attached to an external handle which allowed deflection and rotation of the catheter tip was guided with the aid of image-intensified fluoroscopy. The anatomy of the thyroid venous bed was outlined by serial films during retrograde injection of contrast material

into a thyroid vein. Heparinized blood samples were obtained from the thyroid veins, the large neck veins and from the hepatic, renal and iliac veins. The position of the catheter tip was recorded on a spot roentgenogram for each sample taken (Figure 1). The blood samples were chilled, and the plasma was separated and frozen at -20°C until PTH radioimmunoassay was performed. The sampling procedure usually took from one and one-half to two hours, and the patients were ambulatory within three hours thereafter.

Arteriography

Two patients underwent bilateral selective thyroid arteriography. Under local anesthesia, the catheter was introduced percutaneously into the femoral artery. Contrast material was injected into the inferior and superior thyroid arteries. Results were evaluated by direct roentgenograms after bony and soft tissue shadows were neutralized by subtraction. A lesion was interpreted to be significant if it appeared as an area of persistent staining without significant uptake on thyroid scanning. The two patients remained supine for six to eight hours after completion

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Table 1

Patient	Sex/Age	Ca (mg/dl)	PO ₄ (mg/dl)	MBL* (ng/ml)	Veins with Elevated PTH	Location of Lesion	Histology Lesion
1	M 57	12.9	2.4	1.3	R.I.T.	Right inferior	Adenoma
2	F 59	11.0	3.4	1.5	C.I.T. L.I.T.	Left superior	Adenoma
3	M 65	11.7	1.7	2.0	R.M.T. R.I.T.	Right inferior	Adenoma
4	M 58	11.7	3.4	3.0	R.I.T. R.S.T.	Right inferior	Adenoma
5	F 58	11.5	2.9	2.0	R.I.T.	Right inferior	Adenoma
6	F 39	11.1	3.5	0.4	None	Not explored	—
7	F 67	13.0	2.5	3.6	R.M.T. L.I.T.	Right paratracheal area	Adenoma
8	M 49	11.3	2.6	1.0	None	Mediastinum	Adenoma
9	M 47	11.0	2.7	0.4	L.I.T.	Not explored	—
10	F 59	11.0	3.0	0.6	C.I.T. R.I.J.	Right superior	Adenoma

*BL=Mean background level of parathyroid hormone

I.T.=Right inferior thyroid

C.T.=Common inferior thyroid

L.T.=Left inferior thyroid

M.T.=Right middle thyroid

S.T.=Right superior thyroid

I.J.=Right internal jugular

of the procedure. No complications occurred.

Parathyroid hormone radioimmunoassay

Parathyroid hormone was determined by radioimmunoassay as previously reported.⁸ ¹²⁵I-bovine

parathyroid hormone was prepared, and either pure bovine or a partially purified preparation from human glands was used as standard. The normal range for fasting adults is 0.3 to 0.8 ng/ml (human standard). Samples were processed at one or more dilutions in quadruplicate.

The mean background level of PTH (MBL) represents the average concentration in plasma samples taken from three separate peripheral veins below the diaphragm. The concentration of hormone greater than twice the mean background level in a particular vein was considered abnormal and indicative of parathyroid hyperactivity.

Surgery

Definitive surgery was performed by members of the Department of Surgery at Duke University Medical Center and the Durham Veterans Administration Hospital. Patients were explored through a cervical incision; in one patient, mediastinal exploration was necessary.

RESULTS

Radioimmunoassay of PTH in venous samples

In seven of the ten hyperparathyroid patients the mean background level of PTH was above the normal range. In seven patients unilateral elevations of parathyroid hormone were detected and bilateral elevations were detected in one patient. In two patients levels of PTH in the small thyroid veins and large neck veins did not differ appreciably from the mean background level.

Arteriography

Two patients in this series (3 and 5) had selective thyroid arteriogra-



Fig. 1A. The catheter is placed in the right superior thyroid vein. The contrast material outlines the right side of the thyroid venous plexus. (RIJ=Right internal jugular vein, RST=Right superior thyroid vein, RIT=Right inferior thyroid vein, CIT=Common inferior thyroid



Fig. 1B. The catheter is placed in the left inferior thyroid vein and contrast material outlines the left side of the thyroid venous plexus. (CIT=Common inferior thyroid vein, LIT=Left inferior thyroid vein, RIT=Right inferior thyroid vein).

phy performed prior to venous catheterization. In both of these patients a parathyroid stain was demonstrated arteriographically. Great caution must be exercised in performing arteriography in this anatomical region. Extravascular dissection of the contrast media, arterial occlusion and inadvertent vertebral artery injection, although infrequent, can lead to severe neurological sequelae.

Surgical findings

Eight of the ten patients underwent surgical exploration, and in each a single parathyroid neoplasm was found. Both sides of the neck were explored in each patient, and in six (75 percent) the side of the neck harboring the parathyroid lesion had been correctly predicted preoperatively (Table 1). In all three patients who had not been previously explored (1, 2, and 5) the parathyroid lesion was correctly localized by elevated PTH levels. In patient 5 a parathyroid lesion was also identified by arteriography. A representative venogram with PTH

data from one of these patients (2) is shown in Figure 2.

Five of the ten patients (3, 4, 7, 8, and 10) had been previously explored for hyperparathyroidism, and in three the lesions were correctly localized preoperatively by our studies. In one of these patients (3) arteriography was performed prior to venous catheterization. The arteriogram which demonstrated an adenoma and the venous catheterization data which confirmed localization are shown in Figure 3. In patient 8 no elevated level of PTH was detected in the selectively sampled thyroid veins or the large neck veins. At reexploration the absence of a cervical lesion was confirmed; during mediastinal exploration a parathyroid adenoma was found embedded within the thymus gland. In patient 7 bilateral elevations of PTH were present, but only a unilateral parathyroid neoplasm was found in the right paratracheal area at surgery.

Postoperatively, all patients undergoing surgery experienced a decrease in the serum calcium concen-

tration, and none has developed recurrent hypercalcemia.

Of the two patients not yet explored, one (6) had no detectable elevation of PTH in the neck vein. Previously this patient had a three and one-half gland parathyroidectomy for renal osteodystrophy, and she has subsequently maintained mild hypercalcemia. She probably has a persistent autonomous hyperfunctioning glandular remnant. The other unexplored patient (9) had hypercalcemia and an elevated level of PTH in the left inferior thyroid vein.

DISCUSSION

Doppman and Hammond⁹ first predicted that PTH measurement of plasma from selectively catheterized thyroid veins might be helpful in localizing parathyroid neoplasms. They demonstrated by arteriographic studies that, after injection of a single inferior thyroid artery, the venous drainage was ipsilateral by way of the inferior thyroid vein in 17 of 20 cases. The classic studies of Halsted and Evans¹⁰ have shown that the inferior parathyroid glands nearly always received the blood supply from the inferior thyroid artery and the superior parathyroid glands either directly from this artery or from its ascending anastomotic ramus. Doppman therefore, concluded that the inferior thyroid vein should drain the effluent of the ipsilateral inferior and superior parathyroid glands. This postulation has subsequently proved to be correct. Bilezikian and associates,¹¹ in a recent review of the cumulative experience with this technique, at four centers, have shown that parathyroid neoplasms can be localized if PTH levels are determined in plasma from each inferior thyroid vein. Even with superior parathyroid lesions where multiple veins are sampled, the highest level of parathyroid hormone is nearly always detected in the ipsilateral inferior thyroid vein. One should thus speak of lateralizing rather than localizing parathyroid neoplasms since, with a unilateral elevation in plasma PTH, one cannot distinguish whether the inferior, the superior, or, indeed, both parathy-

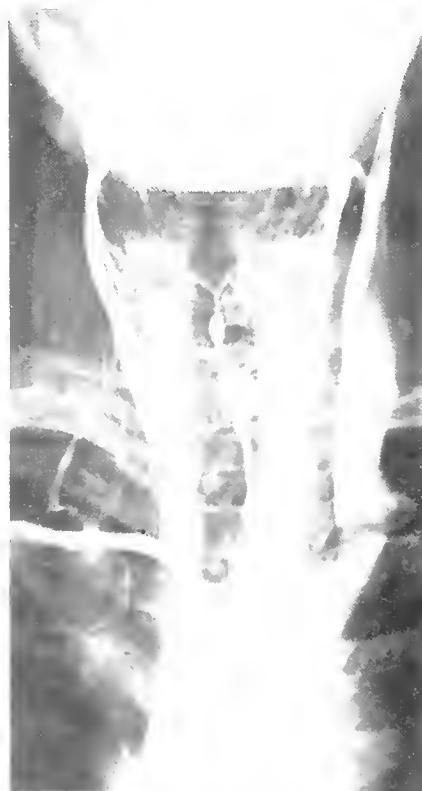


Fig. 2A. Venogram of patient 2 demonstrating thyroid venous plexus.

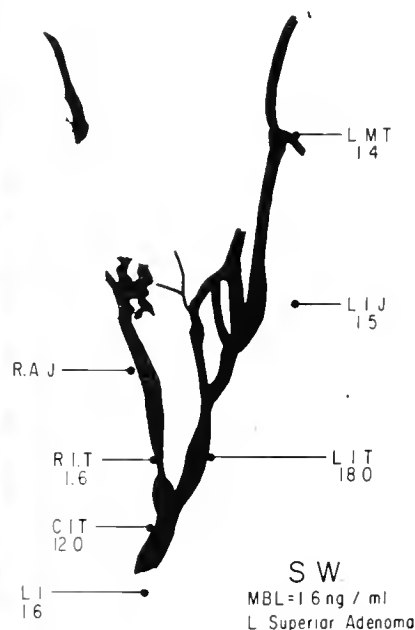


Fig. 2B. PTH data from patient 2. (LIT=Left inferior thyroid vein, CIT=Common inferior thyroid vein, RIT=Right inferior thyroid vein, LI=Left innominate vein, LIJ=Left internal jugular vein, LMT=Left middle thyroid vein, RAJ=Right anterior jugular vein).

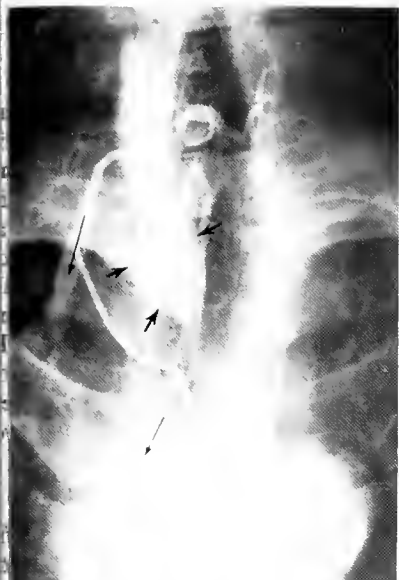


Fig. 3A. Right inferior thyroid arteriogram (late phase) in patient 3. The catheter is in the right inferior thyroid artery. The right inferior parathyroid adenoma (three short arrows) is demonstrated below the right thyroid lobe. The upper long arrow denotes the course of the right middle thyroid vein; the lower long arrow overlies the right inferior thyroid vein.

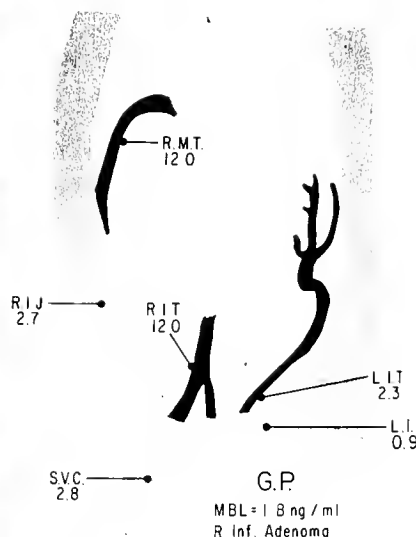


Fig. 3B. Depicts PTH levels in selectively catheterized thyroid veins of patient 3. (R.M.T.=Right middle thyroid vein, R.I.T.=Right inferior thyroid vein, L.I.T.=Left inferior thyroid vein, L.I.=Left innominate vein, R.I.J.=Right internal jugular vein, S.V.C.=Superior vena cava).

id glands are hyperfunctional.

In the catheterization data from patient 2 (Figure 2), the level of PTH in the right inferior thyroid vein is the same as the MBL, whereas the level in the left inferior thyroid vein is much higher. This information strongly suggests the presence of a left-sided parathyroid adenoma. In Bilezikian's study,¹¹ it was found that of 49 patients having bilateral elevations in PTH, 47 (95 percent) had parathyroid adenomas. Conversely, of 20 patients having lateral elevations in PTH, 17 (85 percent) had bilateral parathyroid adenomas.

Figure 2 shows that the level of PTH in the left inferior thyroid vein is much higher than the PTH level in the large neck veins. Contrary to earlier reports,^{12, 13} PTH measurement in the large neck veins is as helpful as PTH measurement in the small thyroid veins^{14, 15}; presumably this is because of the great dilution that occurs between the thyroid venous bed and the large neck veins. This is not to say that large neck veins should be sampled, for occasionally

they give unique information, as demonstrated in patient 10 (Table 1). She was the only patient in our series in whom the PTH level in a large vein (right internal jugular) was higher than that in any thyroid vein, and this sample was critical for lateralizing her lesion.

This technique affords a great degree of accuracy in lateralizing parathyroid lesions preoperatively in those patients who have not been previously explored, being successful in 45 of 54 patients (86 percent) in Bilezikian's series¹¹ and in all three of the patients in our present study. It is this group of people, however, in whom this localization technique is least indicated. One would expect an experienced parathyroid surgeon to find the lesion(s) at the initial exploration.

In the hyperparathyroid patient who has been unsuccessfully explored previously, the reoperation is technically more difficult, primarily because scarring encumbers the surgeon's effort to preserve the recurrent laryngeal nerve and the normal parathyroid glands. In this group of patients, however, one encounters

the greatest difficulty in catheterizing the small thyroid veins, since they are commonly ligated during prior surgery. Indeed, in our five reoperative patients selective venous catheterization data were of localizing value in only three. In a previous study of 15 patients undergoing re-exploration for hyperparathyroidism, Wells and associates¹⁶ found that it was especially helpful to perform selective superior and inferior thyroid arteriography prior to performing venous catheterization for PTH determination. Not only were capillary stains, demonstrative of parathyroid lesions, occasionally seen, but more importantly venous drainage patterns were located, facilitating subsequent selective catheterization and PTH determination. Of 11 patients undergoing arteriography, seven (66 percent) had parathyroid lesions which demonstrated vascular stains. Of 15 patients undergoing selective venous catheterization and subsequent parathyroid hormone determination, 12 (80 percent) had their lesions localized. Of 11 patients undergoing both selective thyroid arteriography and venous catheterization, ten (90 percent) had their lesions localized. It is our current policy not to use selective venous catheterization in patients with hyperparathyroidism who have not been previously explored. Rather, the technique is reserved for those patients who are undergoing reexploration for hyperparathyroidism, and then it is used in combination with selective superior and inferior thyroid arteriography.

We feel that this localization technique has great utility in selected patients and that it is the most accurate and specific method of localizing parathyroid lesions preoperatively. Although the availability of the technique is currently limited, it is likely to assume wider usage in the future.

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... Drs. Regnard and Paul Loye had been present at an execution at Troyes; they even rode in the van which carried the body from the scaffold. One hour after the execution the heart still beat; yet this man's existence was over; he had lost his personality, and yet his heart was beating! Well, to us and to everyone a decapitated person is a dead man, although his heart does continue to contract!—*Death and Sudden Death*, P. Brouardel, 1897, p. 20.

Editorials

THE FALL 1974 EXECUTIVE COUNCIL MEETING

Dr. Wingate Johnson, in his first editorial commenting on the role of the NORTH CAROLINA MEDICAL JOURNAL, noted that the JOURNAL was "a newly born infant" and that "its features may change greatly as it reaches adolescence and maturity." Dr. Robert Richard, 24 years later, when he became editor, observed that the prognosis of the JOURNAL as, to quote Dr. Johnson, "a medium for North Carolina doctors to use in exchanging ideas" was good because the changes in medicine demanded adequate means for the dissemination of information. The JOURNAL, now aged 35, has reached a hardy, but not overripe, maturity by trying to identify its constituency, physician and patient, and to serve as well as possible in a world of rapidly changing expectations brought about by equally rapid changes in medical knowledge and means.

That the North Carolina Medical Society has been part to these changes and to its increasing responsibilities in such a world can be confirmed by the annual fall meeting of the Executive Council, with President Frank R. Reynolds presiding. After Mr. Donald L. Clifford of the St. Paul Insurance Company presented actuarial data relating to a proposed 8 percent rate increase in professional liability insurance, the Council voted unanimously to approve the proposal as recommended by the Committee on Professional Insurance; the Council also voted to so inform the State Commissioner of Insurance, Mr. Ingram, who must approve the increase. Even with the increase, North Carolina would still have the fifth lowest state rates in the nation.

A statement of the Society's financial status was afforded by the report of the Committee on Finance, presented by its chairman, Dr. T. Tilghman Herring. Perhaps the most important of the detailed items considered and approved was the establishment of an operating reserve fund. The chairman of the Professional Service Committee, Dr. Bernard Wansker, and Dr. David S. Johnston, immediate past-chairman of its Blue Shield subcommittee, then discussed proposals to improve claims adjudication, which will be considered further at the Executive Council meeting in February 1975. Dr. John Glasson, speaking for the Council on Review and Development, described, with particular reference to the Annual Session, plans for improved coordination and increased efficiency in administration — efforts designed to get rid of

excessive bureaucratic baggage, a perpetual problem for any dynamic institution.

In a special report which, perhaps more than any other item considered, focuses on what the state of the art is and will be, Dr. M. Frank Sohmer, president of the North Carolina Medical Peer Review Foundation, Inc., outlined the current and projected activities of that organization. Working under a contract with the Department of Health, Education and Welfare for the development and support of the PSRO areas in the state, the Foundation can point to significant steps in six of these areas. It has also contracted with the Social Services administration for a twelve-month review of Medicaid involvement in effective, skilled nursing beds involving 6,000 patients. Moreover, the Foundation, in collaboration with the Department of Human Resources, is concerned with the development of a quality module which should be of significant practical value.

More mundane, and consequently more indicative of the scope of the Society's responsibilities, were the Commission reports. Dr. John McCain's Public Relations Committee was concerned with such matters as the proposed school of veterinary medicine, the value of elective preceptorships with active practitioners for senior medical students, minimum standards of performance for ambulance drivers and attendants, and the status of the antisubstitution law for prescriptions. Dr. Wansker's Professional Service Commission reported on preparations for peer review, the implications of regional variations in fee scales and the need to develop appropriate mechanisms to anticipate and cope with the manifold problems presented to the committees of his commission.

Dr. Josephine Newell, speaking for the Annual Convention Committee, won the enthusiastic congratulations of the Council with her succinct presentation, again proving that "brevity is the soul of wit." Although the deliberations of the Advisory and Study Commission did not permit such compression, Dr. Roy Bigham nonetheless managed his Commission's report with grace and propriety. On behalf of the Administration Commission, Dr. Hewitt Rose noted with regret the resignation of Dr. Jesse Caldwell, Jr., as chairman of the Retirement Savings Plan Committee; the Executive Council expressed its deep thanks and gratitude for the devoted and effective service performed by Dr. Caldwell during his long tenure.

Speaking for the Developing Government Health

Programs Commission, in the absence of its chairman, Dr. John McLeod, Jr., Dr. M. Frank Sohmer neatly cut through jargon in outlining the implications of Public Law 16204 which considers cost-containment, long-term planning and the development of alternative systems for service in contemporary medicine. He further reviewed the present status of Comprehensive Health Planning (CHP) and suggested ways in which physicians can participate effectively in this enterprise. He alluded to the gratifying results of the Henderson County Consumer Health Survey which revealed patients' satisfaction with the medical care in that county. The report of the Public Service Commission, given by its chairman, Dr. Philip G. Nelson, was the last major representation and provided pertinent data from its many active subcommittees.

WILLIAM McNEAL NICHOLSON, M.D.

For many years the JOURNAL and the Society have enjoyed the wise counsel of Dr. Nicholson. He joined the Board in 1949, and became chairman

in 1959. The two editors the JOURNAL has had thus far fully appreciated this thoughtful, mature and deliberate man.

The new editor will not be so fortunate, for on September 8, 1974, Dr. Nicholson died unexpectedly. Dr. Nicholson came to Duke when he and the school were both young, and both heavily indebted to his alma mater, Johns Hopkins. A native of Bath, he was coming back to the state he loved with the intention of doing all he could to make its medical practice better. In his work with diabetic patients at Duke in his duties in postgraduate education there, and in his editorial board activities this objective was evident. Mrs. Nicholson shared his interests, and she came to know as much about JOURNAL operation as any other member of the Board, attending the annual meetings faithfully.

People of broad experience and outlook are rare in any situation; Nick's wisdom will long be missed by his successors on the Board of this JOURNAL and elsewhere in his sphere of activity.

R.W.P.

Emergency Medical Services



PROPOSED TRAINING PROGRAM FOR EMT ADVANCED TRAINING

**Rocco Morando, Executive Director
National Registry of
Emergency Medical Technicians**

The National Registry of Emergency Medical Technicians, recognizing the need for an EMT career ladder and for registration at a higher level, is currently developing the necessary criteria for EMT advancement through its "Standards, Training and Examination Committee."

The Committee, chaired by Kenneth F. Kimball, M.D., of Kearney, Nebraska, consists of the following:

Eugene L. Nagel, M.D., Los Angeles, California
Richard S. Scott, M.D., Los Angeles, California
Leonard Rose, M.D., Portland, Oregon
George W. Hyatt, M.D., Washington, D. C.
A. Abbatiello, Ph.D., Chicago, Illinois
Morrie Davidson, Ed.D., Los Angeles, California
Joseph Kadish, Ph.D., DHEW — Washington, D. C.
Mr. Robert Motley, NHSTA-DOT—Washington, D. C.
Harlan Felt, R.E.M.T.A., Riverside, Illinois

Ed Vernoneau, R.E.M.T.A., Springfield, Massachusetts

J. D. Farrington, M.D., Board Chairman (ex officio)

Rocco V. Morando, Executive Director (ex officio)

At a recent meeting of the Board of Directors the National Registry has approved (in concurrence with the U.S. Department of HEW and the National Highway Traffic Safety Administration, DOT) the development of a higher level of EMTs, based upon the recommendation of the "Standards, Training, and Examination Committee." The required level of knowledge and skills will include the following:

1. Hold a current EMT-A rating.
2. Develop advanced abilities in triage and general evaluation of the patient(s).
3. Airway management
 - Endotracheal
 - Suctioning
 - Intubation
 - Positive pressure ventilation
 - Extraordinary measures (i.e. cricothyrotomy, etc.)

4. I.V. or I.M. medications
 - Venipuncture
 - Needle
 - Catheter
 - Fluids and electrolytes
 - Medications
 - Common lifesaving drugs (Digitalis and antibiotics to be excluded)
5. Cardiac arrest
 - CPR retraining
 - Use of a monitor and its interpretation
 - Defibrillation
 - Telemetry
 - Intracardiac injection
6. Management of the unconscious patient
 - Coma
 - Diabetic medications
 - Anticonvulsants
7. Trauma
 - Sterile technique
 - Wound care and dressings
 - Head injuries
 - Spinal injuries
 - Immobilization of fractures
8. Anatomy and Physiology

As indicated for each of above areas to enable the student to understand what he is doing and why it is done this way.

The Committee, working in concert with the many disciplines involved in advanced EMT activities, will finalize the necessary curriculum for the identified tasks. After pilot testing has been completed, the National Registry will implement registration as an EMT-Advanced by way of appropriate examinations, both written and practical.

Additional information relative to the progress and status of the "Registered EMT-Advanced" will be distributed via the Registry Newsletter and other EMS related publications.

The Registry asks that all qualified EMTs, interested in registration as an EMT-Advanced, contact the Registry office, P. O. Box 29233, 1395 East Dublin-Granville Road, Columbus, Ohio 43229.

From "Emergency Medicine Today," Commission on Emergency Medical Services, Volume 3, No. 8, August 1974, John M. Howard, M.D., Editor. Original article may be obtained from the American Medical Association, 535 North Dearborn Street, Chicago, Illinois 60610.

Bulletin Board

NEW MEMBERS of the State Society

Alexander, John Eugene, M.D. (ORS), 1600 Welch Pl., Charlotte 28216
 Allen, Elms Leach, M.D. (IM), 1405 Plaza Dr., Winston-Salem 27103
 Arnold, William Warren, M.D. (OPH), 3801 Sunset Ave., Rocky Mount 27801
 Bove, John Albert, Jr., M.D. (GS), 603 Beaman St., Clinton 28328
 Corrie, Donald Patrick, M.D. (U), Bowman Gray, Winston-Salem 27103
 Davis, Jerome Irvin, M.D. (Intern-Resident), 3790-H Moss Dr., Winston-Salem, 27106
 Eason, Flynn Keels, M.D. (OTO), 225 Hawthorne Ln., Charlotte 28204
 Esham, Cecil Tracy, Jr., M.D. (N), 100 Victoria Rd., Asheville 28801
 Evans, Irving Barefoot, M.D. (Intern-Resident), 1287 Tredwell Dr., Winston-Salem 27103

Fresca, Victor Atilio, M.D. (R), Pine Knoll Towns 32, Morehead City 28577
 Harkins, Paul Duane, M.D. (ORS), 200 E. Northwood St., Greensboro 27401
 Harriss, William Fred, M.D. (R), 1712 Windsor Dr., High Point 27262
 Jackson, Robert Davis, M.D. (PDC), 1929 Randolph Rd., Charlotte 28207
 Johnson, Harry Lester, Jr., M.D. (GP), (Renewal), 210 W. Wendover Ave., Greensboro 27401
 Niemeyer, Charles John, M.D. (ORS), P.O. Box 2046, Gastonia 28052
 Pressly, James Allen, M.D. (ORS), Ste. 114, 1928 Randolph Rd., Charlotte 28207
 Reavis, Wilton McLean, Jr., M.D. (Intern-Resident), 28-F Stratford Hills Apts., Chapel Hill 27514
 Rogers, Larry Arch, M.D. (NS), 1012 Kings Dr., Charlotte 28283
 Simpson, John Larry, M.D. (Intern-Resident), 710 Lance Dr., Newport News, Va. 23601
 Smith, Charles Wilson, Jr., M.D. (Intern-Resident), B-10, Village Apts., Carrboro
 Sullivan, Raymond Charles, Jr., M.D. (IM), 3422 Deep Green Dr., Greensboro 27401
 White, Thomas Walker, III, M.D. (FP), 905 N. Queen St., Kinston 28501

WHAT? WHEN? WHERE? In Continuing Education

Note: (1) Programs sponsored by the Bowman Gray, Duke or UNC Schools of Medicine are approved for "Category I" AMA Physician Recognition Award credit, and for AAFP "Prescribed" continuing education credit when such approval has been granted by the AAFP. (2) "Place" and "Sponsor" are indicated below only where these differ from the place and group or institution listed under "For Information."

In North Carolina November 15-16

Anesthesiology Fall Seminar
Place: Charlotte Memorial Hospital Auditorium
Fee: \$40.00
For Information: Dr. H. A. Ferrari, Chairman, Department of Anesthesiology, Charlotte Memorial Hospital, P. O. Box 2554, Charlotte 28201

November 18

Planning Patient Care
For Information: Judith E. Wray, Administrative Secretary, Continuing Education Program, UNC School of Nursing, Chapel Hill 27514

December 3-4 & 5-6

The Nursing Audit
Place: Dec. 3-4, Humanities Lecture Hall, UNC-Asheville; Dec. 5-6, Southwest Technical Institute, Sylva
Sponsor: Health Education Commission of Western North Carolina
Fee: \$7.00
For Information: Mrs. Marian S. Martin, P. O. Box 7607, Asheville 28807

December 4 (changed from November 3)

Burn Symposium
Place: Babcock Auditorium. Time: 12:30-5:30 p.m.
Fee: \$10.00
Credit: 5 hours
For Information: Emery C. Miller, M.D., Associate Dean for Continuing Education, Bowman Gray School of Medicine, Winston-Salem 27103

December 5

American College of Physicians—North Carolina Society of Internal Medicine, Annual Meeting
Place: Holiday Inn Four Seasons, Greensboro
For Information: John T. Sessions, Jr., M.D., Department of Medicine, UNC School of Medicine, Chapel Hill 27514, or, John L. McCain, M.D., Wilson Clinic, Wilson 27893

December 5-6

2nd North Carolina Postgraduate Course on Pulmonary Disease
Place: Velvet Cloak Inn, Raleigh
Sponsors: North Carolina Thoracic Society, North Carolina Lung Association and North Carolina Academy of Family Physicians
Fee: \$25.00—Enrollment is limited. Applications will be accepted in order received.
Credit: This program is acceptable for ten elective hours by the American Academy of Family Physicians.
For Information: C. Scott Venable, Executive Director, North Carolina Lung Association, P. O. Box 127, Raleigh 27602 (919-832-8326)

December 6-7

What's New in Newborn Care
Place: Babcock Auditorium
Fee: \$45.00
Credit: nine hours AAFP credit
For Information: Emery C. Miller, M.D., Associate Dean for Continuing Education, Bowman Gray School of Medicine, Winston-Salem 27103

Randomycin[®] (methacycline HCl)

CONTRAINDICATIONS Hypersensitivity to any of the tetracyclines.

WARNINGS Tetracycline usage during tooth development (last half of pregnancy to eight years) may cause permanent tooth discoloration (yellow-gray-brown), which is more common during long-term use but has occurred after repeated short-term courses. Enamel hypoplasia has also been reported. **Tetracyclines should not be used in this age group unless other drugs are not likely to be effective or are contraindicated.**

Usage in pregnancy (See above **WARNINGS** about use during tooth development.) Animal studies indicate that tetracyclines cross the placenta and can be toxic to the developing fetus (often related to retardation of skeletal development). Embryotoxicity has also been noted in animals treated early in pregnancy.

Usage in newborns, infants, and children. (See above **WARNINGS** about use during tooth development.)

All tetracyclines form a stable calcium complex in any bone-forming tissue. A decrease in tubula growth rate observed in prematures given oral tetracycline 25 mg/kg every 6 hours was reversible when drug was discontinued.

Tetracyclines are present in milk of lactating women taking tetracyclines.

To avoid excess systemic accumulation and liver toxicity in patients with impaired renal function, reduce usual total dosage and, if therapy is prolonged, consider serum level determinations of drug. The anti-anabolic action of tetracyclines may increase BUN. While not a problem in normal renal function, in patients with significantly impaired function, higher tetracycline serum levels may lead to azotemia, hyperphosphatemia, and acidosis.

Photosensitivity manifested by exaggerated sunburn reaction has occurred with tetracyclines. Patients apt to be exposed to direct sunlight or ultraviolet light should be so advised, and treatment should be discontinued at first evidence of skin erythema.

PRECAUTIONS If superinfection occurs due to overgrowth of nonsusceptible organisms, including fungi, discontinue antibiotic and start appropriate therapy.

In venereal disease, when co-existent syphilis is suspected, perform darkfield examination before therapy, and serologically test for syphilis monthly for at least four months.

Tetracyclines have been shown to depress plasma prothrombin activity. Patients on anticoagulant therapy may require downward adjustment of their anticoagulant dosage.

In long-term therapy, perform periodic organ system evaluations (including blood, renal, hepatic).

Treat all Group A beta-hemolytic streptococcal infections for at least 10 days.

Since bacteriostatic drugs may interfere with the bactericidal action of penicillin, avoid giving tetracycline with penicillin.

ADVERSE REACTIONS Gastrointestinal (oral and parenteral forms): anorexia, nausea, vomiting, diarrhea, glossitis, dysphagia, enterocolitis, inflammatory lesions (with monilial overgrowth) in the anogenital region.

Skin maculopapular and erythematous rashes, exfoliative dermatitis (uncommon). Photosensitivity is discussed above (See **WARNINGS**).

Renal toxicity rise in BUN, apparently dose related (See **WARNINGS**).

Hypersensitivity urticaria, angioneurotic edema, anaphylaxis, anaphylactoid purpura, pericarditis, exacerbation of systemic lupus erythematosus.

Bulging fontanels, reported in young infants after full therapeutic dosage, have disappeared rapidly when drug was discontinued.

Blood hemolytic anemia, thrombocytopenia, neutropenia, eosinophilia.

Over prolonged periods, tetracyclines have been reported to produce brown-black microscopic discoloration of thyroid glands; no abnormalities of thyroid function studies are known to occur.

USUAL DOSAGE Adults—600 mg daily, divided into two or four equally spaced doses. More severe infections, an initial dose of 300 mg followed by 150 mg every six hours or 300 mg every 12 hours. Gonorrhea. In uncomplicated gonorrhea, when penicillin is contraindicated, Randomycin (methacycline HCl) may be used for treating both males and females in the following clinical dosage schedule: 900 mg initially, followed by 300 mg q.i.d. for a total of 5.4 grams.

For treatment of syphilis, when penicillin is contraindicated, a total of 18 to 24 grams of Randomycin (methacycline HCl) in equally divided doses over a period of 10-15 days should be given. Close follow-up, including laboratory tests, is recommended.

Eaton Agent pneumonia: 900 mg daily for six days.

Children—3 to 6 mg/lb. day divided into two to four equally spaced doses.

Therapy should be continued for at least 24-48 hours after symptoms and fever have subsided.

Concomitant therapy Antacids containing aluminum, calcium or magnesium impair absorption and are contraindicated. Food and some dairy products also interfere. Give drug one hour before or two hours after meals. Pediatric oral dosage forms should not be given with milk formulas and should be given at least one hour prior to feeding.

In patients with renal impairment (see **WARNINGS**), total dosage should be decreased by reducing recommended individual doses or by extending time intervals between doses.

In streptococcal infections, a therapeutic dose should be given for at least 10 days.

SUPPLY Randomycin (methacycline HCl) 150 mg and 300 mg capsules, syrup containing 75 mg/5 cc methacycline HCl.

Before prescribing, consult package circular or latest POR information.

Rev 6/73



WALLACE LABORATORIES
CRANBURY, NEW JERSEY 08512

Is He a Source of Information?

Yes, with certain reservations. The average sales representative has a great fund of information about the drug products he is responsible for. He is usually able to answer most questions fully and intelligently. He can also supply reprints of articles that contain a great deal of information. Here, too, I exercise some caution. I usually accept most of the statements and opinions that I find in the papers and studies which come from the larger teaching facilities. It goes without saying that a physician should also rely on other sources for his information on pharmacology.

Training of Sales Representatives

Ideally, a candidate for the position as a sales representative of a pharmaceutical company should be a graduate pharmacist who has a questioning mind. I don't think this is possible in every case, and so it becomes the responsibility

of the pharmaceutical company to train these individuals comprehensively. It is of very great importance that the detail man's knowledge of the product he represents be constantly reviewed as well as updated. This phase of the sales representative's education should be a major responsibility of the medical department of the pharmaceutical company.

I am certain that most of these companies take special care to give their detail men a great deal of information about the products they produce—information about indications, contraindications, side effects and precautions. Yet, although most of the detail men are well informed, some, unfortunately, are not. It might be helpful if sales representatives were reassessed every few years to determine whether or not they are able to fulfill their important function. Incidentally, I feel the same way about periodic assessments of everyone

in the health care field, whether they be general practitioners, surgeons or salesmen.

Value of Sampling

I personally am in favor of limited sampling. I do not use sampling in order to perform clinical testing of a drug. I feel that drug testing should rightly be left to the pharmacology researcher and to the large teaching institutions where such testing can be done in a controlled environment.

I do not use samples as a "starter dose" for my patients. I do, however, find samples of drugs to be of value in that they permit me to see what the particular medication looks like. I get to see the various forms of the particular medication at first hand, and if it is in a liquid form I take the time to taste it. In that way I am able to give my patients more complete information about the particular medications that I prescribe for them.

capacity they are indeed useful; particularly in the fact that they disseminate broadly based educational material and serve not just as "pushers" of their drugs.

The Other Side of the Coin

Obviously, the pharmaceutical companies are not producing all this material as a labor of love—they are in the business of selling products for profit. In this regard the ambitious and improperly motivated sales representative can exert a negative influence on the practicing physician, both by presenting a one-sided picture of his product, and by encouraging the practitioner to depend too heavily on drugs for his total therapy. In these ways, the salesman has often distorted objective reality and undermined his potential role as an educator.

The Industry Responsibility

Since the detail man must be an information resource as well as representative of his particular pharmaceutical company, he should be carefully selected and

thoroughly trained. That training, perforce, must be an ongoing one. There must be a continuing battle within and with the pharmaceutical industry for high quality not only in the selection and training of its sales representatives, but also in the development of all of its promotional and educational material.

The industry must be ready to accept constructive as well as corrective criticism from experts in the field and consumer spokesmen, and be willing to accept independent peer review. The better educated and prepared the salesman is, the more medically accurate his materials, the better off the pharmaceutical industry, health professionals and the public—i.e., the patients—will be.

Physician Responsibility

The practicing physician is in constant need of up-dated information on therapeutics, including drugs. He should and does make use of drug information and answers to specific questions supplied by the pharmaceutical representative. However, that informa-

tion must not be his main source of continuing education. The practitioner must keep up with what is current by making use of scientific journals, refresher courses, and information received at scientific meetings.

The practicing physician not only has the right, but has the responsibility to demand that the pharmaceutical company and its representatives supply a high level of valid and useful information. I feel certain that if such a high level is demanded by the physician as well as the public, this demand will be met by an alert and concerned pharmaceutical industry.

From my experience, my impression is that sectors of the pharmaceutical industry are indeed ethical. I challenge the industry as a whole to live up to that word in its finest sense.

Pharmaceutical
Manufacturers Association
1155 Fifteenth Street, N.W.
Washington, D. C. 20005



December 11-12

Hospital Emergency Room and Ambulatory Care
Place: Benton Convention Center, Winston-Salem
Sponsors: North Carolina Hospital Association and the North Carolina Medical Society
Program: Designed for hospital administrators, trustees and physicians.
For Information: Mrs. Diane Turner, North Carolina Hospital Association, P. O. Box 10937, Raleigh 27605
Phone (919) 834-8484

January 24-25

Surgical Infections
Fee: \$75.00
Credit: 12 hours
For Information: Emery C. Miller, M.D., Associate Dean for Continuing Education, Bowman Gray School of Medicine, Winston-Salem 27103

January 31-February 1

North Carolina Medical Society 1975 Conference for Medical Leadership
Place: State Society Headquarters Building, Raleigh
Program: Designed especially for Society Officers and other members who carry leadership responsibility. Open to all interested Society members.
For Information: Mr. William N. Hilliard, Executive Director, North Carolina Medical Society, P. O. Box 27167, Raleigh 27611

February 14-15

Medical Ethics Symposium
Place: Babcock Auditorium
Fee: \$30.00
Credit: 15 hours
For Information: Emery C. Miller, M.D., Associate Dean for Continuing Education, Bowman Gray School of Medicine, Winston-Salem 27103

February 19

Paraneoplastic Syndromes—the Wingate Johnson Memorial Lecture
Place: Babcock Auditorium
Time: 11:00-12:00 a.m.
Speaker: Prof. A. McGehee Harvey, M.D., Johns Hopkins Hospital, Baltimore, Maryland
For Information: Emery C. Miller, M.D., Associate Dean for Continuing Education, Bowman Gray School of Medicine, Winston-Salem 27103

March 17-21

Tutorial Postgraduate Course: Radiology of the Gastrointestinal Tract
Place: Governors Inn, Research Triangle Park (between Durham and Raleigh, near the airport.)
Program: Designed for radiologists, but open to other physicians in training or practice. Emphasis on personalized, tutorial type teaching, with ample opportunity for discussion. Two 80-minute tutorial sessions each morning, and one in the afternoon; 12 registrants will join one faculty member in a separate quiet room with viewboxes for organized film reading-discussions and case presentations. Each registrant will have a total of 14 different tutorial sessions. One hour "Panel" presentation-discussion each afternoon. Guest faculty include: Drs. Charles A. Bream, Harley C. Carlson, Joseph T. Ferrucci, Jr., Roscoe E. Miller, Jerry C. Phillips, Bernard S. Wolf, and, from Kings College Hospital, London, England, Dr. John Laws, Chairman, Department of Radiology.
Fee: \$300; enrollment limited.
Credit: 28 hours AMA "Category One" accreditation
For Information: Robert McLelland, M.D., Department of Radiology, Box 3808, Duke University Medical Center, Durham 27710

April 4-5

Pediatrics Postgraduate Course
Place: Babcock Auditorium
Sponsors: Continuing Education, Bowman Gray School of Medicine, and the Maternal and Child Health Section of the State Board of Health
Fee: \$35.00
Credit: 12 hours
For information: Emery C. Miller, M.D., Associate Dean

for Continuing Education, Bowman Gray School of Medicine, Winston-Salem 27103

Continuing Education via Satellite

The following programs are scheduled to be received from the ATS-6 communications satellite, by the veterans' hospitals at Fayetteville, Oteen and Salisbury on the dates indicated. Sessions are open to all physicians and other interested health professionals.

November 20—1 p.m., "Radiology Conference"
November 27—1 p.m., "Patient Histology Tissue Conference"

December 4—1 p.m., "TBA Conference"
December 11—1 p.m., "Neurological Conference"
December 18—1 p.m., "Psychiatry Conference"
December 25—No program, due to holidays

As this schedule has been subject to some change, please check with one of the following before attending:

Fayetteville—Mr. Kenneth Gath (488-2120)
Oteen—Stewart Scott, M.D., or Mary Ellen Lutz, R. (298-7911)
Salisbury—Mr. Dante Spagnolo (636-2351)

Programs in Contiguous States

December 5-6

46th Annual McGuire Lecture Series—Advances in Obstetrics and Gynecology
Sponsors: Department of Continuing Education and Department of Obstetrics and Gynecology, and the H. Hudnal Ware, Jr., Society
Fee: \$75.00
Credit: Nine and one-half prescribed hours AAFP applicable for; AMA accredited
For Information: David B. Walthall, III, M.D., Director, Continuing Medical Education, Medical College of Virginia, Box 91, MCV Station, Richmond, Virginia 23298

December 5-8

Core Curriculum: Clinico-Pathologic Correlations in Cardiovascular Disease
Place: Williamsburg Conference Center, Williamsburg, Virginia
Fee: ACC members \$125; non-members \$175
Credit: Accredited by State Board of Education in Maryland and by AMA Council on Medical Education.
For Information: Miss Mary Anne McInerney, Director, Department of Continuing Education Programs, American College of Cardiology, 9650 Rockville Pike, Bethesda, Maryland 20014

December 6-8

Neurologic Problems of Infancy and Childhood
Place: Cascades Meeting Center, Williamsburg, Virginia
Sponsors: University of Virginia School of Medicine, Medical College of Virginia of Virginia Commonwealth University; Eastern Virginia Medical School
Fee: \$85.00 Enrollment limited to 80 registrants.
Credit: 13½ prescribed hours AAFP credit applied for.
For Information: Dr. Ronald B. David, Medical College of Virginia, Box 211, MCV Station, Richmond, Virginia 23298

January 8, 15, 22, 29

Medical Hypnosis
Place: Porter Auditorium (sixth floor), Sanger Hall.
Time: 7-9 p.m.
Fee: \$50.00
For Information: Dr. Charles E. Smith, Department of Psychiatry, Medical College of Virginia, Box 907, MCV Station, Richmond, Virginia 23298

January 25

Ventilatory Problems Workshop
Place: Holiday Inn, Oak Ridge, Tennessee 37830
For Information: Doris Croley, Oak Ridge Hospital of the United Methodist Church, Oak Ridge, Tennessee 37830

February 28-March 2

Annual Meeting Virginia Chapter American Academy of Pediatrics
Place: Colonial Williamsburg, Virginia
Fee: \$10.00
For Information: James H. Stallings, Jr., M.D., Secretary

Treasurer, Virginia Chapter American Academy of Pediatrics, 6503 N. 29th Street, Arlington, Virginia 22213

April 26-30

International Biomaterials Symposium

Sponsors: Clemson University and the National Institute for Dental Research

Fee: \$150

For Information: Professor J. K. Johnson, Continuing Engineering Education, 116 Riggs Hall, Clemson University, Clemson, S. C. 29631

Items submitted for listing should be sent to: WHAT? WHEN? WHERE?, P. O. Box 8248, Durham, N. C. 27704, by the 10th of the month prior to the month in which they are to appear.

AUXILIARY TO THE NORTH CAROLINA MEDICAL SOCIETY

AMA-ERF

Currently within the Auxiliary—particularly during the “giving” season of Christmas—a lot can be heard about “amaerf.”

“I’m an amaerf, are you?”

In case this conjures up mental pictures of a very weird thing indeed, we hasten to explain that amaerf—or AMA-ERF, as it is properly depicted—is the American Medical Association Education and Research Foundation. It consists of 90,000 women working together with their husbands in medicine to lend a helping hand to making funds available so that many struggling young physicians can finish their education. The goal for 1974-1975 is “a million dollars more,” preferably as much as \$2 million, following on the heels of last year when AMA-ERF broke the million dollar barrier—the goal of last year’s national Auxiliary president, Mrs. Willard Sivner.

This means that every Auxiliary member should be a fund raiser for AMA-ERF. It is the greatest joy there is of showing support and interest in the betterment of the medical profession. It is being urged that each member contribute a *minimum* of \$5.00.

There are many enticing ways this can be done near and beyond a check, which is always welcome. Within each Auxiliary various AMA-ERF sponsored items can be purchased:

The Groaning Board—an excellent cookbook, a great gift—\$5.00, 100 percent deductible;

Medicine and Stamps—for the stamp collector—\$5.00, 100 percent deductible;

Note paper, memo pads, postal cards—all free from headquarters in Chicago and the State AMA-ERF Chairman (Mrs. William Corpening, P. O. Box 20, Granite Falls, N. C. 28630). The sale of these is a real profit for AMA-ERF;

Christmas cards—time-tested and profitable for AMA-ERF; and,

Beautiful, *different* watches—these are ordered by the State Chairman and shown several times a year. There is a \$10.00 profit on each watch. (The \$10.00 is deductible on income tax as well.)

There are many other ideas—some very individual ideas which might be shared with all the members. Individual enthusiasm can be a real investment in a young physician. Everyone is urged to encourage the use of *memorial, in honor of, thinking of you* and *thank you* cards which can be ordered, free of charge, from AMA-ERF headquarters in Chicago (Mrs. Helen Mazur, AMA, Department of Circulation and Records, 535 Dearborn Street, Chicago, Ill. 60610) or from the State Chairman. All the donation goes to AMA-ERF; or just send a check to your county AMA-ERF chairman, or state chairman, with instructions (name and address of the honoree), the *medical school to which the donation should go*, and the chairman will handle it in a prompt, careful and thoughtful way.

You can give to the medical school of your choice through the AMA-ERF Auxiliary Fund, just noting the name of the medical school on the bottom of the check. This also can include donations to specific clubs at the school: Co-Founders at the University of North Carolina or the “Davidson Fund” at Duke University, for instance. There has been

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some controversy about this, but it was reascertained by Mr. Robert Enlow at AMA Records Office in Chicago on October 4, 1974. It is suggested, however, that a note be written by the physician donor to the Dean of the medical school informing him that his contribution will be made in this fashion. Thus, he will not lose any privileges from donating through these clubs.

Another choice is to give to the Loan Guarantee Fund, a cooperative effort by American medicine and private enterprise. Loans are issued by various commercial banks directly to students, interns and residents *at the recommendation of the dean of their medical school*. For every dollar the AMA-ERF deposits in a cooperating bank, the bank loans \$12.50 to students. AMA-ERF guarantees the loans.

It is important to stress that the unrestricted grants to medical schools are important because deans of medical schools are always in need of *flexible* financial aid. AMA-ERF funds are given with no strings attached and can be used to solve the most pressing problems. Loans to students at low interest rates are one important thing, of course, but another might afford a medical school the money to retain a valued faculty member being sought after elsewhere at a higher salary.

Through interest in and donations to AMA-ERF, the physicians' wives in North Carolina and all over the United States are showing that they care and share time, thoughts and energies, as well as substance for medical education. That's what it takes to be an "amaerf."

News Notes from the—

UNIVERSITY OF NORTH CAROLINA DIVISION OF HEALTH AFFAIRS

Dr. Morris A. Lipton, professor of psychiatry at UNC-Chapel Hill, was among 25 of the world's leading molecular biologists who met in Gottenger, Germany, in September to examine the influence of genes and biochemistry on mental illness and normal behavior.

Decribing the purpose of the conference, Dr. Lipton said, "There is substantial evidence that a tendency toward mental illness is inherited. There is a genetic predisposition to depression and schizophrenia, just as to high or low intelligence. . . . We now believe that our understanding has advanced far enough that we can intervene to make the organism better able to tolerate its environment."

A retired building contractor, H. D. Dickerson, and his wife operate the H. D. Dickerson Residential Care Facility on their Cypress Lane Farm just outside Chapel Hill.

Two-hundred persons gathered there on September 20 for the dedication of the new home for speech-handicapped children who are being treated at UNC in Chapel Hill.

Dr. Erle E. Peacock of Tucson, Arizona, who delivered the dedication address, played a leading role in developing the UNC program for treating speech disorders when he was a plastic surgeon in the School of Medicine.

For ten weeks, six to eight boys and girls from throughout North Carolina will call the Dickerson farm their home while they undergo treatment for cleft palate-related speech disorders. Each year the UNC Schools of Dentistry and Medicine conduct three programs which include diagnostic testing, treatment and clinical classroom education.

The cleft palate team includes a dozen specialists from the School of Dentistry and Medicine faculties. Director of the Oral-Facial and Communicative Disorders Program is Dr. Robert B. Winslow.

The UNC program is unique in that it is the most comprehensive clinical research cleft palate program in the nation.

* * *

Alumni and former house staff of the Department of Psychiatry at the UNC School of Medicine gathered in Chapel Hill in September to honor Dr. George Ham, the first chairman of the department.

Dr. Douglas Bond, former dean of Case Western Reserve School of Medicine, delivered the opening address. A contemporary of Dr. Ham's, he cited major historic events, sociological trends and scientific discoveries which have molded their generation both professionally and personally.

Dr. David Allen, a San Francisco psychiatrist, who was the first resident in psychiatry at the University, spoke on the treatment of hysteria, and Dr. William McKinney, Jr., professor of psychiatry at the University of Wisconsin School of Medicine, spoke on "Tough and Soft-Headed Psychiatry," which outlined the major split in psychiatry in the United States today.

* * *

Dr. Philip T. Johnson of the UNC School of Medicine at Chapel Hill has been named a Diplomate of the American College of Laboratory Animal Medicine.

He is campus veterinarian for the Department of Laboratory Animal Medicine and an instructor in the Department of Pathology at the UNC School of Medicine.

* * *

Dr. Allen M. Feinberg of the UNC School of Medicine at Chapel Hill has been elected a Diplomate of the American Board of Professional Psychology.

Dr. Feinberg, whose specialty is clinical psychology, is assistant professor of psychiatry.

* * *

Dr. Claude Piantadosi of the UNC School of Pharmacy at Chapel Hill has been awarded a \$24,344

research grant from the U.S. Department of Health, Education and Welfare.

The research entitled "Ether and Ketone Lipids in Brain Development," involves the lowering of serum cholesterol in the cardiovascular system.

Dr. Piantadosi is head and professor of the Division of Medicinal Chemistry in the School of Pharmacy.

* * *

Dr. Rolf P. Lynton of the Carolina Population Center and the UNC School of Public Health in Chapel Hill has been appointed dean and professor of the new School of Public Health of the University of South Carolina at Columbia.

Dr. Lynton has been director of two international projects at the Carolina Population Center and associate professor of mental health in the School of Public Health. He came to Chapel Hill in 1966.

The University of South Carolina School of Public Health will be developed in association with the state's second medical school and will link up programs and academic resources now located in various parts of the Columbia campus and across the state.

News Notes from the—

DUKE UNIVERSITY MEDICAL CENTER

Dr. C. William Erwin, an associate professor of psychiatry here, has been named the first medical director of the Durham-based National Driving Center.

Erwin, 41, is an authority on what makes drivers drowsy and how to detect that drowsiness before it leads to catastrophe. He received his M.D. from the University of Texas in 1960.

Erwin joined the Duke psychiatric faculty five years ago. He will retain his Duke faculty appointment in conjunction with his Driving Center position.

At the Driving Center, now temporarily housed in Duke's Engineering Building, he will direct research—trying to pinpoint the factors affecting a driver's ability.

"Driver error causes most highway accidents," Erwin said, "but paradoxically, the thrust of safety research in this country has been toward improving the road or the car. In contrast, the National Driving Center is focusing on the driver."

Both psychology and medicine contribute to the organization's findings, he added.

The center is a non-profit research group, funded each year by the State of North Carolina, as well as by private sources. It is scheduled to move into permanent quarters at the Research Triangle Park next year.

* * *

one of 19 fellowships awarded in 15 hospitals, universities and cerebral palsy centers by the United

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Cerebral Palsy Research and Educational Foundation has been presented to Dr. William G. Moorefield, Jr., resident in orthopaedic surgery. The fellowship is for \$2,500.

Moorefield received his B.A., M.A. and M.D. degrees at Duke. He completed an internship at the University of Alabama and an assistant residency here. He also served two years with the U. S. Public Health Service Hospital in Cherokee, N. C.

* * *

The urologic clinic has a new name—the Edwin P. Alyea Urologic Clinic, named for a man who came here at the age of 31 to establish the Division of Urology and then headed it for the next 34 years.

The name change was made during a dedication ceremony in the Duke Hospital Amphitheater.

Alyea drove an ambulance in World War I until he became old enough to get into the fighting as a lieutenant in Army heavy artillery. He had graduated from Princeton, and after the war enrolled at the Johns Hopkins Medical School, where he earned his M.D. in 1923.

With internship and residency at Hopkins behind him, he came to Duke to organize the urologic service in 1929. The medical center opened in July 1930.

One of the leaders in his specialty, Alyea was one of the early innovators in prostatic surgery, and his first scientific paper recommended vasectomy. He was a consultant to the Surgeon General in the National Research Council during World War II.

A primary objective was the establishment of a urologic residency, and during the time Alyea was chief of the service, 35 residents completed post-graduate training here. Almost ten years ago his former residents honored him with the establishment of the Edwin P. Alyea Visiting Professorship in Urology.

Alyea relinquished his responsibilities as chief of urology in 1963 and continued as a professor of urology until 1969. He has been an emeritus professor since that time, but has continued to maintain an active affiliation with the division.

* * *

Dr. Johnnie L. Gallemore, Jr., a medical center physician-lawyer, will spend the next 12 months helping Washington legislators draft health bills.

Holder of both law and M.D. degrees, Gallemore is one of six medical educators selected recently for the one-year assignment. A board set up by the National Academy of Sciences and the Robert Wood Johnson Foundation made the selections.

He will be replaced as associate director of medical and allied health education by Dr. William D. Bradford, an associate professor of pathology.

Bradford is no stranger to the post, having filled it in an acting capacity in 1970-1971. He won the Student American Medical Association Golden Apple Award in 1969 for excellence in teaching basic sciences.

Duke has introduced a new program for medical students who want to become health policymakers.

Those admitted to the five-year program will study in the School of Medicine and the Institute of Policy Sciences and Public Affairs. Both an M.D. degree and a master of arts degree in public policy sciences await those who complete it successfully.

The combined approach was adopted because "many people who are health policymakers don't have adequate medical training," explained Dr. Willis Hawley, associate director of the policy sciences institute.

"Or if they do have medical training, they don't have the analytical skills and knowledge of policy implementation they need," he added.

The new Medicine and Public Policy Program will provide all three, Hawley noted.

The first two of the program's five years are spent with medical courses. The third year is devoted to courses in the Institute of Policy Sciences and Public Affairs.

There, students will learn how to analyze policy alternatives and gauge their consequences. They'll learn how government policies are made and put into action. They'll also learn how ethics and policy-making dovetail.

Those students will then complete their medical courses during years four and five, adding health research seminars and a master's paper.

According to Hawley, graduates will be qualified for positions in a variety of public and private organizations, including the National Institutes of Health, the Office of the Surgeon General, the states' departments of human resources or public health, the regional medical programs, the American Medical Association and Blue Cross-Blue Shield.

As many as five students each year will be accepted into the program. They may apply at the same time they apply to the medical school, or during their first two years.

News Notes from the—

BOWMAN GRAY SCHOOL OF MEDICINE WAKE FOREST UNIVERSITY

Thirty-one new faculty members have been appointed at the Bowman Gray School of Medicine, including 15 who were named to the full-time faculty.

Those appointed to the full-time faculty include: Carol A. Appolone, instructor in pediatrics (social work); Dr. William A. Brady, instructor in neurology; Dr. J. Edwin Byrum, Jr., instructor in surgery and instructor in medicine (emergency medical services); Dr. Donald L. Collins, instructor in medicine (rheumatology); James W. Fredrickson, instruc-

or in medical systems planning; David Hunter, instructor in radiology (nuclear medicine technology); Dr. James C. Leist, instructor in community medicine; Dr. Michael D. Parker, assistant professor of medicine (rheumatology); and William C. Park, Jr., instructor in community medicine.

Also Dr. Keith M. Phillips, assistant professor of pediatrics (allergy and immunology); Dr. J. Baldwin Smith, assistant professor of neurology and assistant professor of pediatrics; Sandra E. Stoterau, instructor in pediatrics (speech pathology); Dr. Wilford P. Stratten, assistant professor of physiology, section of pharmacology (neuropharmacology); Dr. Robert T. Westmoreland, assistant professor of anesthesia; and Dr. Douglas R. White, assistant professor of medicine (hematology/oncology).

Those appointed to the part-time faculty include: Dr. Robert F. Blackard, clinical assistant professor of anesthesia; Dr. J. Frances Bounous, clinical instructor in pediatrics; Dr. Paul D. Harkins, clinical instructor in orthopedics; Dr. Thomas J. Koontz, clinical instructor in surgery; Dr. James M. Marlowe, clinical instructor in orthopedics; Dr. Thomas N. Masters, associate in physiology; Dr. H. Bryan Noah, clinical instructor in orthopedics; Dr. Michael J. Polk, clinical instructor in obstetrics and gynecology; Dr. Joyce H. Reynolds, clinical instructor in surgery (emergency medical services); and Dr. Keeling A. Warburton, clinical instructor in obstetrics and gynecology.

In the Division of Allied Health, Dr. Victor D. Morris was appointed associate professor. Drs. Thomas R. Bryan, William H. Burch, James O. Burke and Jack C. Evans were announced as clinical instructors.

* * *

Dr. David L. Kelly, Jr., associate professor of neurosurgery, has been elected secretary of the Congress of Neurological Surgeons.

The election came during the congress's 24th annual meeting in Vancouver, British Columbia.

Dr. Kelly, whose term as secretary runs through 1977, served as chairman of the scientific program for the Vancouver meeting. He has been a member of the congress's executive committee since 1971.

He also is vice president of the North Carolina Neurosurgical Society.

* * *

Dr. John Denham, instructor in the Department of Community Medicine, joined two residents from North Carolina Baptist Hospital recently for a two-week trip to San Pedro Sula in Honduras to provide medical care for victims of Hurricane Fifi.

The residents are Dr. Michael Roberts of surgery and Dr. Richard Sterba of pediatrics.

Their trip was taken under the auspices of the Foreign Missions Board of the Southern Baptist Convention.

* * *

Dr. Jack M. Rogers, assistant professor of psychiatry, has received the first Career Teaching Award

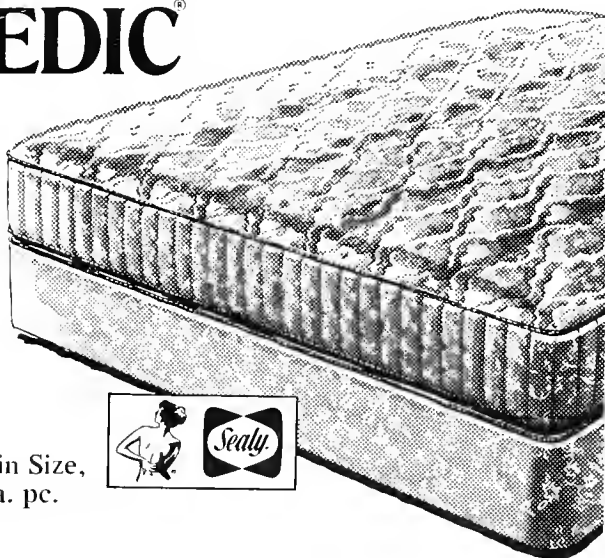
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presented to a member of the Bowman Gray faculty.

The three-year grant is from the National Institute of Alcoholism and Alcohol Abuse in conjunction with the National Institute of Drug Abuse.

Under the grant Dr. Rogers will concentrate his efforts on helping to expand the medical school's curriculum to include more training of medical students, interns and residents in the diagnosis and treatment of alcoholism and drug abuse. He also will be involved in continuing education programs for practicing physicians and paramedical personnel who come into contact with alcoholics and other drug abusers. Research on the causes and treatments of alcoholism and drug abuse will be included in Dr. Rogers' work under the grant.

His efforts will be part of a formal program within the Department of Psychiatry and will involve several other departments.

Dr. Rogers also will coordinate the school's work with community agencies which deal with alcoholics and drug abusers.

* * *

Dr. B. Lionel Truscott, professor of neurology, has been named an alternate member of the Stroke Advisory Committee of the Joint Commission on Hospital Accreditation.

Dr. Truscott also has been nominated as the neurology coordinator for Medical District No. 9, which includes Veterans Administration hospitals in Dur-

ham, Fayetteville, Oteen and Salisbury, N. C., and the V. A. Center at Mountain Home, Tenn.

* * *

The medical school has appointed its first transplant coordinator to assist in the growing kidney transplant and dialysis effort at the medical center.

Miss Becky Norman will be the person to contact for information about all aspects of the kidney program.

The new position is made possible by a grant from the North Carolina Division of Human Resources.

* * *

Dr. Alanson Hinman, associate professor of pediatrics, has been appointed to the Council on Development Disabilities of the North Carolina Department of Human Resources.

* * *

Dr. C. Patrick McGraw, research assistant professor of neurology, has been elected to serve as a member of the Peer Review Committee for the Regional Research Advisory of the American Heart Association. He also has been elected to the Research Review Subcommittee of the North Carolina Heart Association, Inc.

* * *

Dr. I. Meschan, professor and chairman of the Department of Radiology, has been appointed chairman of the Committee on Radiology, National Research Council, Assembly of Life Sciences, Division of Medical Sciences.

Month in Washington

The Senate has overwhelmingly passed legislation that would require one-fourth of all medical and dental school graduates to spend at least two years in the nation's slums and rural areas where there are shortages of physicians.

Earlier the Senate voted down a much more sweeping bill sponsored by Senator Edward Kennedy that would have required mandatory federal service for all health professions students and national licensure and relicensure for physicians and dentists.

Hours before the first Senate vote, Senator Kennedy, aware that he was losing liberal support, shelved his Health Subcommittee's \$5.1 billion, five-year bill and offered a substitute measure which was trounced 57-34. Instead, the Senate adopted a measure sponsored by Senator J. Glenn Beall, Jr.,

(R-Md.), and passed a three-year, \$2 billion health manpower bill by a vote of 81-7.

The bill, finally approved by the Senate, was stripped of most of the controversial provisions of the original Kennedy bill and was a victory for the American Medical Association, the American Dental Association and the Association of American Medical Colleges.

The Senate bill calls for a three-year extension of present federal programs for aiding medical education at a total cost of approximately \$2 billion. Capital grants for medical schools would be continued at a high level despite the administration's request for a cutback.

The Beall substitute measure provides federal aid to medical and dental schools that agree to allocate

percent of their classroom space to students volunteering to serve in areas short of medical care workers. In return for either civilian or federal service under the National Health Service Corps, the students could receive scholarships.

The Kennedy bill would have compelled all medical school graduates to serve in the shortage areas. The approach labeled a "domestic draft" by Senator Hall and his committee colleagues Senators Peter Dominick (R-Colo.) and Robert Taft, Jr., (R-Ohio) also developed the substitute measure.

The Senate bill does not contain the original requirement for a federally appointed National Council on Postgraduate Education with ten regional councils designed to deal with allocation of specialty training posts and foreign medical graduates. The Senators intended that this was too heavy an involvement of the federal government.

Another casualty of the Senate voting was the proposal for federal standards for licensing and releasing physicians and dentists, a plan that stirred wide protest within the professions.

The Maryland Senator's bill represented a middle ground on financial help for medical schools, with the AAMC contending that the amount was too low and the Administration believing it was too high.

Immigration standards would be tightened to restrict the number of foreign medical graduates under the Senate bill.

* * *

On the other side of the Capitol, a House subcommittee has approved a counterpart bill to the Senate manpower legislation that would establish federal scholarships intended to increase the number of physicians in the nation's rural areas and urban areas where there are physician shortages.

The House subcommittee's bill authorizes \$240 million over three years for National Health Service scholarships paying \$9,200 to \$9,500 a year to cover the cost of a medical education.

In return, the scholarship recipients would have to spend two to four years serving in areas with physician shortages. Non-scholarship students who volunteer to practice in areas with physician shortages would receive a guaranteed income of \$28,000 a year until they get their practices started.

The bill would also give medical schools a grant of \$2,100 a year for each student—\$400 less than the schools now receive.

However, any graduate who does not practice in an underserved area would have to repay the government the money given to the medical school.

Though the House bill differs sharply from the Senate version, particularly the Senate provision forcing medical schools to have one-fourth of their classes of federal scholarships requiring two years of practice in underserved areas, the House subcommittee Chairman, Paul G. Rogers, (D-Fla.), believes the difference can be resolved when the two bills go to conference.

Undaunted by collapse of the National Health Insurance (NHI) measure in the House Ways and Means Committee in late summer, Senator Russell Long (D-La.) is forging ahead with plans to ram a bill through the Senate in the strained atmosphere of a "lame duck" Congress. Long is Chairman of the Senate Finance Committee and sponsor along with Senator Abraham Ribicoff (D-Conn.), of an NHI plan featuring Social Security financed and operated catastrophic health insurance plan for all. The Long-Ribicoff bill already enjoys the official support of 25 Senators, and it rates some chance of Senate passage.

The chances of passage of a version of such a Senate bill by the House in a "lame duck" session after the November elections, however, is considered extraordinarily slim.

* * *

President Ford's long-heralded summit economic conference produced relatively little talk about health care costs and inflation, despite the fact that HEW Secretary Weinberger has of late frequently sounded such an alarm.

Nor was there any indication during the Washington parley that the Administration was considering controls at this time, although Senate Majority Leader Mike Mansfield (D-Mont.) urged the 800 delegates to request such controls.

However, it became clear to conference observers that the President will ask Congress to approve certain but unspecified tax changes and to cut the federal budget to combat inflation.

American Medical Association President Malcolm C. Todd, a delegate to the summit conference, said that he agreed with the President with respect to avoiding controls at this time—"particularly discriminatory cost controls."

"Every American, every physician, has the duty to assist in solving the number one problem of the nation—inflation," Dr. Todd said, noting that the AMA has repeatedly stressed the need for restraints by physicians in avoiding unjustifiable charges and fee increases.

A summary of the earlier pre-summit session on health was presented by Michael Zubkoff, Professor of Health Economics at Meharry Medical College and Vanderbilt University. He said, "It is generally recognized that the health sector is both a hostage and a cause of inflation."

According to Professor Zubkoff, the pre-summit meeting had determined certain "structural defects" in the health care delivery system which included:

(1) Fee-for-service payment for physicians and cost-plus reimbursement for hospitals . . . encourages cost growth. (2) First dollar insurance coverage reduces cost-consciousness by consumers. (3) Consumers lack knowledge to become aggressive, informed purchasers of health care.

According to Zubkoff, among the "common themes" stressed at the pre-summit health conference

were: that the federal commitment to health care should not be reduced; that structural reform is needed; and, that existing incentives and regulatory mechanisms are inadequate.

"There was a definite lack of a widespread consensus on solutions to cost problems in health during the pre-summit meeting," Zubkoff told the summit meeting.

While pleased that President Ford had not called for wage-price clamps by the federal government, Dr. Todd at the same time criticized the Administration for "singling out" health by "annualizing" monthly consumer price index levels. The practice of projecting the yearly increase on the basis of what happens during one month or several months has been followed only on "health" by the HEW Department so as to bolster its contention that the health segment should be isolated for controls, Dr. Todd charged.

The AMA President noted that in the past three years physicians' fees have risen 17.6 percent, compared with 22.9 percent for the economy as a whole and 32.9 percent for legal charges.

Suggested steps to curb medical costs, listed by Dr. Todd, were preadmission testing; expansion of ambulatory care services; earlier discharge from hospitals; avoidance of unnecessary hospitalization; reducing wasteful testing, prescribing and treatment; and, decreasing the cost of malpractice insurance.

In addition, Dr. Todd explained, there must be incentives to produce more family physicians and a plan for needed specialists only.

"Perhaps physicians should attempt voluntarily to guide their fee-setting decisions by tying their charges to the consumer price index levels and not exceeding them," Dr. Todd suggested.

* * *

A wide range of health care-related subjects was discussed at a recent meeting between an AMA delegation and Health, Education, and Welfare Secretary Caspar Weinberger.

Malcolm Todd, M.D., President of the AMA, said the Secretary and his aides were told that the AMA desires the best possible national health insurance (NHI) program that can be worked out, but cautioned against any hurry-up approval in an emotionally-charged Congress late in the session.

Dr. Todd said that he emphasized inflation as being the number one problem facing the nation at present and, therefore, any NHI program should have a minimal impact on this problem. AMA officials urged that NHI be kept outside the Social Security Administration.

The AMA delegation urged that controls not be reimposed on the medical profession, citing the AMA's urging of moderation by physicians to keep fees in line with expenses.

Other subjects at the meeting included manpower

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legislation and current procedural terminology.

The AMA delegation included, in addition to Dr. Todd, Richard Palmer, M.D., Chairman of the AMA Board of Trustees; Russell Roth, M.D., Past President; William Holden, M.D., board member; Ernest Livingstone, M.D., chairman of the Council on Legislation; James Sammons, M.D., Executive Vice President Designate; Joe Miller, Deputy Executive Vice President; Whalen Strobhar, Assistant Executive Vice President; and Harry Peterson, director of the legislative Department.

* * *

The Food and Drug Administration is planning a letter to physicians alerting them to a series of studies, to be published in *Lancet*, a British medical journal, that finds a higher-than-normal incidence of breast cancer among women aged 60 and older who have been treated with reserpine for high blood pressure. A panel of experts appointed by the HEW Department will review the data.

* * *

The Food and Drug Administration has indicated to Congress that it will order warning labels placed on oral diabetic preparations when a new study of the drug's safety and efficiency is published soon.

Alexander Schmidt, M.D., FDA Commissioner, told the Senate Monopoly Subcommittee headed by

Senator Gaylord Nelson that the FDA endorses a 1970 study by the University Group Diabetes Program which found that the drugs (tolbutamide and phenformin) were linked with a heart disease death rate twice as high as that for diabetics taking insulin or no drug at all through diet.

Within a few weeks, an 18-month audit of the 1970 study is due to be published, and apparently it backs up the major findings of previous study. The audit is being prepared by a special panel of the Biometrics Society.

Lawsuits challenging the FDA's right to impose warning labels have deterred the agency from action to date, Dr. Schmidt told the Subcommittee. He said that many physicians have something close to a "religious belief" that the oral diabetic preparations, by lowering blood sugar, decrease the likelihood of cardiovascular complications among diabetics.

The major opponent of relabeling is the Committee on the Care of the Diabetic, composed of 180 physicians. The issue is a serious controversy among specialists in the treatment of diabetics, with experts taking both sides.

The FDA is relying on the audit to strengthen its hand sufficiently in the legal fight to allow it to go ahead with warning labels, but the prospects are that the actual implementation of such an order will be tied up in the courts for some time.

Book Reviews

Stress Without Distress. By Hans Selye, M.D. 171 pages. Price, \$6.95. Philadelphia and New York: J. P. Lippincott Company, 1974.

Stress Without Distress is dedicated "to those who to find themselves." No matter how hard I try to have it otherwise, my prejudices begin pumping any mention of a book purporting to help people find themselves. The gaggle of these literary endeavors which hardly ever get off the ground has caused me to dislike all such offerings even before I begin to read them.

Some similar prejudice must have prompted a reviewer to produce a descriptive gem with regard to a book written by one of my colleagues. The reviewer observed that it was the "least worst" book of its kind that he had ever read. My temptation to tag Hans Selye's *Stress Without Distress* with some such description indicates that it has mellowed my prejudices, but has not abolished them, as a result of reading the book.

With some glaring exceptions, it is a well written document. Chapter 2 on "Motivation" is especially noteworthy. One of its sections, "Work and Leisure," is exceptionally good, as to both content and style. What I take to be the author's personal charm and irrepressible good will emanate from his writing. His ability to take justifiable pride in his own accomplishments strikes a healthy note. Selye's genius for communicating medical and scientific theories and facts to laymen may constitute his finest talent as a writer. I have no competence for determining the validity of his medical and scientific observations, but they are communicated with clarity and verve.

The theme of the book begins with a distinction between stress and distress. The latter is always to be avoided. Stress can be either good or bad, depending upon the way the person reacts to the demands which life makes upon him. People can learn how to react successfully to life's stresses by taking their cues from the way in which body cells and organs react.

Cells and organs have an instinct for survival, as well as a tendency toward cooperation with one another as a means of survival. They are sometimes syntonic and sometimes catatonic in response to stress—the first making for peaceful coexistence with the stress or stressor, and the second trying to fight it off. What is indispensable to the cells or person under stress is the quality of homeostasis: "The body's tendency to maintain a steady state despite external changes; physiological 'staying power.'"

"Altruistic egotism" is the best guarantor for the homeostasis in human behavior and relationships. This term appears to mean that a person's apparent altruism is basically egotistical. He does good for others in order to assure his self-fulfillment. Since I cannot love my neighbor as myself, I should set out to earn the love of my neighbor. I think Selye ought to be paraphrased somewhat like this: Because you cannot love your neighbor as you love yourself, try to get your neighbor to love you as he loves himself.

The flow of the book toward its central theme is impeded by excessive repetitions and summaries, one after the other. Thirty-five of the book's 171 pages

contain a glossary, a bibliography and an index. Selye seems overly concerned that the reader will not remember what has been said in the span of 136 pages. I was somewhat irritated by his efforts to remind me many times of what had already been stated.

Although careful with a number of definitions, the author makes no attempt to define "altruistic egotism." Since the expression is certainly a contradiction in terms, Selye has no right to assume that the reader will accept it without question. Because his entire argument stands on the acceptance of "altruistic egotism," Selye's failure to reconcile the two words is almost unforgivable.

In a second instance, the author boldly states that his "code is, at the same time, both compatible with and independent of, any religion, political system, or philosophy." As one whose profession is linked with the first of these categories, I am not aware of the facile compatibility between Selye's code and Christianity. Much more proof than the author supplies is assuredly indicated.

Most astounding is this assumption: "He who follows our doctrine will greedily hoard wealth and



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length, not in the form of money or domination of others, but by earning the good will, gratitude, respect, and love of those who surround him. Then, even if he has neither money nor power to command, he will still be virtually unassailable and safe, for no one would have a personal reason to attack him." Does Selye really believe that attackers wait for reasons? As a matter of fact, I want to buffet him more than once simply because he appears to be so outlandishly happy with himself and the world.

Almost everything that Selye prescribes is easier said than done. Therefore I suggest that the book is not for sinners. Selye tells us that he is not a sinner and refuses to think of himself in that context. Since I am a sinner, I must declare that Selye does not speak to my condition as cogently as does the apostle Paul. His confession is mine as well: "I do not understand my own actions. For I do not do what I want, but I do the very thing I hate." I want to do what Dr. Selye prescribes, but I probably won't.

WARREN T. CARR, D.D.

The Ethics of Genetic Control: Ending Reproductive Roulette. By Joseph Fletcher, 218 pages. Price, \$1.95. Garden City, New York: Anchor Press/Doubleday, 1974.

The moral and ethical problems posed by recent discoveries in modern biology and genetics, in general, and in human reproduction, in particular, provide the substance of this book. As a theologian emeritus, now professing medical ethics, Dr. Fletcher appears well qualified for his task. Seven previous volumes on social and medical ethics attest to his familiarity with the territory. In six "Some" chapters starting with "Some Ideas," he considers in turn Facts, Doubts, Issues, Answers, and Hopes. Written in a lively style, the book explores not only what is now but what *may be*, because, as the author argues, few would have guessed a decade or two ago where we would be today.

Dr. Fletcher believes that there is no logical connection or scientific pathway from what is or may be to what ought to be. As an admitted consequential ethicist, he asserts that "in any moral calculus human need is the principal value." He opposes any universal standard or *a priori* ethic other than human need. In his "Answers" chapter he boldly deals with the moral and ethical aspects of adultery, artificial germination, birth defects, cloning, cost-benefit ratios, surrogate mothering, love-making and other subjects of moral and ethical concern.

Some of Dr. Fletcher's views will prove surprising, if not shocking, to the reader. For instance, in a brief discussion of mass screening, he accepts involuntary sterilization as a reasonable possibility when two people carrying the same hidden recessive gene chance to marry. Although such a practice would slightly reduce the frequency of that particular gene, the cost of making such a practice feasible might well be better borne in finding alternative solutions

to our genetic dilemma. Geneticists agree that present medical advances which permit survival of and reproduction by some people who might otherwise die prior to reproduction do not produce dramatic changes in gene frequency. In other words, we have time to examine various alternatives. Unfortunately, some people will seize upon such pronouncements as evidence of where consequential ethics may lead us.

Since Dr. Fletcher is neither a physician nor a geneticist, a few errors of fact in his book are not surprising. For example, on page 61 he states that ten percent, instead of 25 percent, is the proportion of offspring who have sickle cell anemia from a mating of two carriers. Similarly, in answering critics of cloning (page 75) he concludes, "All that limits I.Q. now, as far as its neurologic apparatus is concerned, is size of the pelvis." Varying from species to species, animal intelligence appears to be correlated to brain size, but among human beings brain size is only weakly correlated to I.Q. (Jonathan Swift's brain volume was 2,000 cc; Anatole France's was 1,100 cc). Although eschewing pejoratives, Dr. Fletcher slips in a footnote on page 105 in describing "nasty little seminarians." Few of us can remain unmoved by growing public knowledge and concern about modern medicine and, in particular, its moral and ethical dimensions. This book provides an excellent opportunity for us to examine primarily the utilitarian or pragmatic ethic as related to some current and future medical practices.

H. O. GOODMAN, Ph.D.

Handbook of Poisoning. By Robert H. Driesbach, M.D. 8th ed. 517 pages. Price, \$6.50. Los Altos, California: Lange Medical Publications, 1974.

Now in its eighth edition, this handbook has 500 additional references. It maintains its traditional, basic style and provides a concise summary of diagnosis and treatment of clinically important poisons.

The book is divided into six sections. The first section deals with the diagnosis and emergency management of poisons in general. It touches on vital subjects such as coma, convulsions, cardiac arrest, shock acidosis and how to treat the patient in such emergency situations. The other five sections deal with specific poisons: agricultural, industrial, household, animal and plant, and medicinal drugs. The main drug is briefly described regarding its primary use, fatal dose, mechanism of poisoning, clinical symptoms, laboratory findings and treatment.

The author has well tabulated much useful data on many drugs and poisons. He has included information on the availability of antisera of reptiles and spider venoms from different sources throughout the world.

This handbook is useful for the physician who treats the patient and for the toxicologist who is interested in studying toxicity of poisons and drugs.

Z. K. SHIHABI, Ph.D.

In Memoriam

Frederick William Stocker, M.D.

Dr. Frederick William Stocker died at his home in Durham on June 6, 1974, after an extended illness.

Dr. Stocker was born in Lucerne, Switzerland, October 14, 1893. He was educated in the schools of Lucerne. He obtained his M.D. degree at the University of Bern. His postgraduate training was done at the University Eye Clinic, Bern, and University Eye Clinic, Munich, Germany. He returned to Lucerne to practice ophthalmology. In 1941 he came to the United States, where he was first associated with the Institute of Ophthalmology, Presbyterian Hospital, Columbia University, and later with the Wilmer Eye Institute of Johns Hopkins University. In March 1942 he became affiliated with McPherson Hospital. He later joined the staffs and faculty of Watts Hospital, Duke University Medical Center and the University of North Carolina School of Medicine.

Fred Stocker was a most remarkable man. He was very proud of his Swiss heritage, but he was equally proud of his newly adopted country. He was a warm, gracious person who enjoyed life. He had many varied interests, other than medicine, and was well versed in art, music and literature. Dr. Stocker was loved and held in the highest esteem by his students, colleagues and patients alike.

An internationally renowned ophthalmologist, he was the author of many publications in his specialty. Although he was keenly interested in all phases of

ophthalmology, his special interest was in the area of corneal transplantation, where he made major contributions.

He was Professor Emeritus of Ophthalmology, Duke University School of Medicine, Associate Clinical Professor of Ophthalmology, University of North Carolina School of Medicine and Ophthalmic Surgeon, McPherson Hospital. He was a member of the AMA, Durham-Orange County Medical Society, Southern Medical Society, American Board of Ophthalmology, American Ophthalmological Society, American Academy of Ophthalmology and Otolaryngology, Swiss Ophthalmological Society (past president), Societe Francaise d'Ophthalmologie, and Chairman of the International Medical Commission for the examination of prisoners of war (Geneva Convention) in the U.S.A. during World War II.

Dr. Stocker was a member of the First Presbyterian Church, the Durham Rotary Club, and he was past president of the Rotary Club of Lucerne. He was also a member of the Board of Directors of the Pestalozzi Foundation of America.

Surviving are his widow, Mrs. Mary Anne Steiner Stocker, three daughters, Mrs. Maya Powell of Norfolk, Virginia, Mrs. Gabrielle Bouchard of San Jose, California, and Mrs. Evelyn Ireland of Seattle, Washington, and six grandchildren.

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Medical Journal

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IN THIS ISSUE: Obstetrical and Neonatal Services in North Carolina, Edward H. Bishop, M.D., and George W. Brumley, M.D.; An Unusual Case of Miliary Tuberculosis: Prolonged Survival with Untreated Miliary Tuberculosis, Peter W. Munt, M.D.; A Five-Year Study of Uric Acid, Cholesterol, and Selected Fitness Variables in Professional Men, William P. Marley, Ph.D., William E. Smith, Ed.D., A. C. Linnerud, Ph.D., William H. Sonner, M.S., Chauncey L. Royster, M.D., and Albert L. Chasson, M.D.

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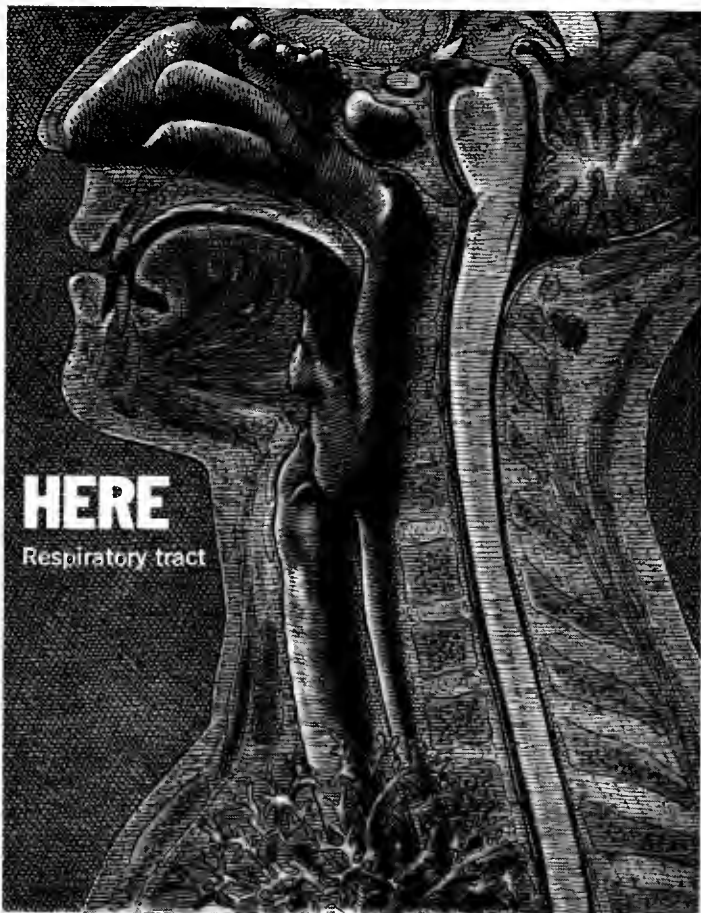
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Obstetrical and Neonatal Services in North Carolina

Edward H. Bishop, M.D.,* and George W. Brumley, M.D.†

NUMEROUS factors, including high perinatal mortality rates, rapidly escalating costs of medical care, and the current enthusiasm for regionalization of perinatal services, have prompted many groups to take a critical look at the status of maternal and newborn services of their individual areas. Almost all such studies raise the question of the wisdom and the necessity of maintaining small obstetrical and newborn services. The National Study of Maternity Care, sponsored by the American College of Obstetricians and Gynecologists (ACOG), indicated that full obstetrical services "... can only be provided efficiently when more than fifteen hundred deliveries occur a year."¹ The ACOG study stated further, "... in more sparsely populated communities limited but adequate service can be provided with a reasonable efficiency when five-hundred patients are delivered at the hospital per year."² A subcommittee of the Michigan State Medical Society reported, "... the subcommittee takes a position that no hos-

pital obstetrical department should exist unless it cares for more than five-hundred deliveries annually."³ The Michigan subcommittee also made an exception by stating, "... the only exception to this position is that the smaller departments may occasionally be justified in Michigan on the basis of the communities' geographic isolation."³

The status of perinatal hospital services in North Carolina has recently been surveyed under the auspices of the Task Force on Maternal and Infant Care, which was appointed by the Governor's Advisory Council on Comprehensive Health Planning.⁴ The Task Force Hospital Survey reconfirmed information available from the Division of Health Services, Department of Human Resources, for 1972. These data are presented as a matter of information and are available for every hospital, community and county in our state.

In 1972 one-hundred thirty-four hospitals in North Carolina reported one or more births. Distribution of these hospitals by the annual number of births is illustrated in Figure 1. Sixty-nine (52 percent) of the hospitals reported fewer than 500 annual births; 118 (88 percent) reported fewer births than the optimum number recommended by the ACOG study. There is little question that, from the fiscal aspect, the

smaller services find it impossible to function as efficiently as the larger services, but a more important question concerns the ability of the smaller services to provide ideal or complete medical care. Traditionally, obstetrical and neonatal results are judged by maternal, fetal and neonatal death rates. In the year under review, too few maternal deaths occurred to permit analysis by size of the hospital services. Fetal death rates, controlled by the size of the obstetrical services, are illustrated in Figure 2. They demonstrate that in 1972, with the exception of those institutions reporting between 1,001 and 2,000 births, there was a direct relationship between the fetal death rate and the annual number of births. When the combined data for a five-year period were used, this trend was less evident, but again, in this instance, the lowest fetal death rates were reported by those institutions reporting more than 2,000 births. An analysis of neonatal death rates (Figure 3) reveals similar trends — a direct relationship between the number of births and the neonatal mortality rate. Again, the most favorable rate was reported by those institutions which had more than 12,000 deliveries. This trend also was less evident when five-year averages were used, but the highest rate was reported by the smallest hospitals,

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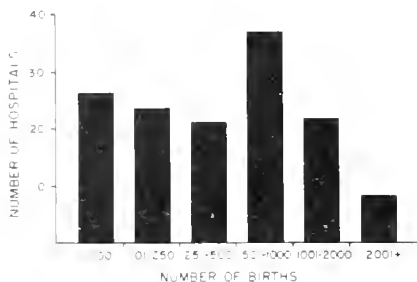


Fig. 1

DISTRIBUTION OF 134 HOSPITALS
BY NUMBER OF BIRTHS (1972)

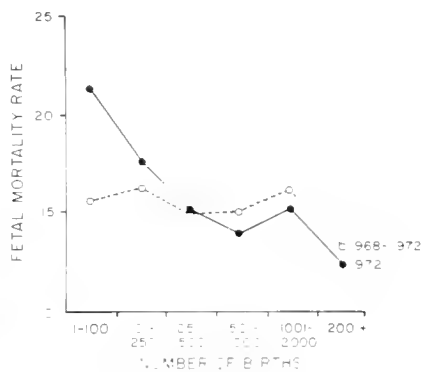


Fig. 2

FETAL MORTALITY RATE BY
ANNUAL NUMBER OF BIRTHS

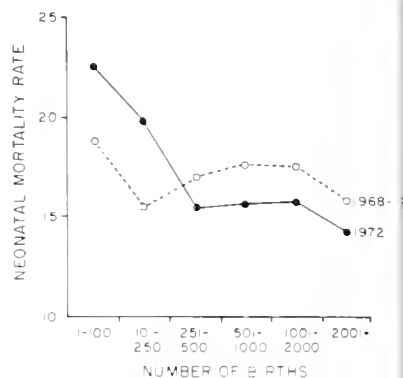


Fig. 3

NEONATAL MORTALITY RATE BY
ANNUAL NUMBER OF BIRTHS

and the lowest rate by the largest.

The frequency of prematurity is probably the most important factor influencing the neonatal mortality rate. The relationship of these two factors is shown in Figure 4. Those institutions with the highest neonatal mortality rate did report a disproportionately higher percent of infants with a birth weight less than 2,500 grams. The largest hospitals (those with 2,000 or more births) reported the lowest neonatal mortality rate and the lowest percent of newborns of low birth weight.

Numerous reasons justifying the continued maintenance of the smaller obstetrical services are often presented. Among these are previous and current existence of facilities, local community pride, and pressures by local physicians. However, the most important and most easily justified reason is the necessity of maintaining hospital services within a reasonable distance from the pa-

tients it serves. As will be shown by subsequent data, in North Carolina it is often difficult to demonstrate this as a valid reason for the maintenance of small services—services which we must accept as having certain inherent disadvantages.

Figure 5 represents the geographic distribution of obstetrical and neonatal services in North Carolina in 1972. Each black circle represents an area with a radius of approximately seven miles surrounding each hospital providing maternity and pediatric care. Expansion of this arbitrary "service area" to a radius of 15 to 20 miles would not seem unreasonable and would illustrate that almost every obstetrical patient, with the exception of a few residing in sparsely populated areas, is currently within one hour's transportation (15 to 20 miles) of an obstetrical service. An even more important observation is that there is a duplication and overlapping of competitive obstetrical and neonatal services, even when the conservative seven-mile radius of a service area is

used. The use of the larger, but still practical, radius would make this duplication even more evident and conspicuous. These observations lead to an obvious question: Could not many obstetrical and neonatal services in North Carolina be combined with the resultant improvement of both medical care and efficiency, without jeopardizing the care of patients and without imposing hardships on any segment of the population?

In subsequent publications we shall discuss the utilization of current hospital facilities, distribution of manpower, and the current status of prenatal care and reproductive outcomes in various geographic areas.

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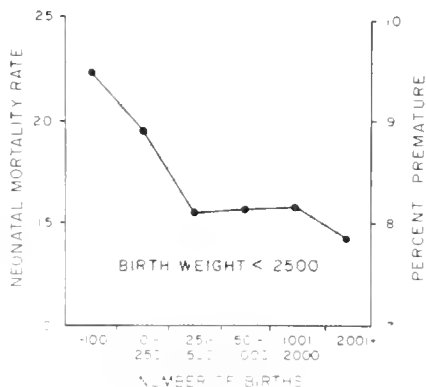


Fig. 4

NEONATAL MORTALITY RATE
AND PREMATURITY RATE BY
NUMBER OF BIRTHS

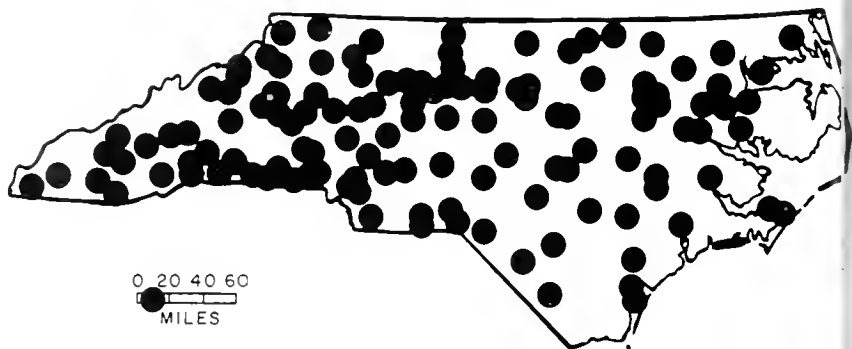


Fig. 5

GEOGRAPHIC DISTRIBUTION OF OBSTETRICAL AND NEONATAL SERVICES

An Unusual Case of Miliary Tuberculosis: Prolonged Survival with Untreated Miliary Tuberculosis

Peter W. Munt, M.D.

In recent years, with the decline of new cases of tuberculosis, many other causes are now considered in the differential diagnosis of granulomatous diseases. Noncaseating granulomas are usually considered more specific for sarcoidosis, erythema nodosum, syphilis, lymphoma, tumor-draining lymph nodes and mycoses. However, it is often overlooked that early mycobacterial granulomas, especially in miliary tuberculosis, exhibit no caseation for many weeks prior to the development of typical central necrosis. Herein is reported a third case of tuberculous peritonitis of the unusual noncaseating type in association with miliary tuberculosis. Included is an outline of the difficulties in diagnosing tuberculous peritonitis and a discussion of the dangers inherent in the assumption that failure to recover tubercle bacilli from noncaseating peritoneal granulomas essentially excludes tuberculous etiology.

CASE REPORT

A 53-year-old black man was admitted to a hospital in March 1972 for treatment of "pneumonia

and flu," although there was apparent improvement. Readmission three weeks later was necessary because of fever, sweats, a 70 pound weight loss, and right upper quadrant abdominal pain. Apparently no cause for these complaints could be ascertained, apart from nonvisualization of the gall bladder. A tuberculin skin test PPD-S (5TU) was non-reactive. A celiotomy performed in May 1972 revealed diffuse, dense infiltrations of the entire peritoneum

with 0.5 to 1.0 mm nodules; the liver and spleen were not enlarged. The histologic pattern was that of noncaseating granulomas (Figure 1); special stains and cultures of the material were unrevealing for mycobacteria and fungi; talc particles were not visualized. At this time the chest roentgenogram revealed bilateral diffuse miliary shadowing (Figure 2). In addition, a review of the chest roentgenograms of March 1972 strongly suggested a similar,



Fig. 1. Peritoneal histologic sections with multiple noncaseating granulomas. Special stains did not demonstrate acid-fast bacilli. (H & E, x 185).

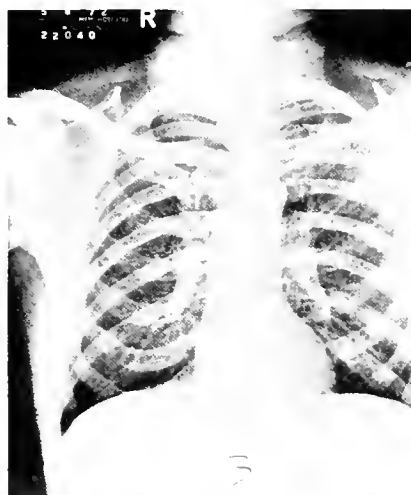


Fig. 2. Classical bilateral miliary shadowing. No areas of chronic tuberculous foci are seen.

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albeit less distinct, pattern.

On a clinical and histological basis it was concluded likely that the patient had sarcoidosis, and a decision was made to treat him initially with corticosteroids. After the ninth day of steroids, streptomycin 1,000 mg daily and isoniazid, 300 mg daily for ten days were administered, and the patient showed clinical improvement. He was then discharged from the hospital on a regimen of isoniazid and ethambutol. Because he was feeling quite well, the patient decided to discontinue his medications. Five weeks later (July 1972) he awakened with a headache, malaise, fever and profound weakness which persisted for one week; he was admitted to the hospital because of disorientation, ataxia, temperature of 103 F, blood pressure of 160/100, and pulse rate of 100 beats per minute. Muscular and mildly obese, he showed marked disorientation and delirium. Complete neurologic evaluation showed only torsion of the neck to the right and pronounced nuchal rigidity; no choroidal tubercles were seen. The remainder of the physical examination showed only diffuse voluntary guarding of the abdomen and a well-healed, right upper quadrant laparotomy scar; there was no hepatosplenomegaly or ascites.

Laboratory data included a hematocrit reading of 45 percent, white blood cell count (WBC) of 8,500 per mm³ with 80 percent polymorphs. Urinalysis, blood urea, serum electrolytes, calcium, and SGOT were normal. Spinal fluid examination revealed an opening pressure of 530 mm water with 128 white cells (88 percent lymphocytes), 304 mg dl protein, and 76 mg dl sugar. Culture of the spinal fluid was positive for *M. tuberculosis*, the organisms being fully sensitive to commonly used antituberculosis drugs. In addition, it was discovered that a gastric fluid culture, reported two months earlier, was positive for *M. tuberculosis*. PPD-S (5TU) was 8 mm at 48 hours.

Therapy consisted of a regimen of isoniazid, streptomycin, rifampin and adrenal steroids. The patient's mental status gradually improved,

and eventually he was discharged on a regimen of isoniazid, ethambutol and pyridoxine. At present (January 1974) he continues to have some neurologic sequelae (short attention span, ataxia and poor recent memory) although he has no further abdominal pain and his chest roentgenogram is normal.

DISCUSSION

This report is remarkable from several points of view. First, it poignantly demonstrates the pitfalls inherent in the common misconception that noncaseating granulomas are usually caused by sarcoidosis or other nonmycobacterial diseases which may be responsive to corticosteroids. Indeed, in the present study the patient had established miliary dissemination of *M. tuberculosis* for a period of more than five months, and steroids alone would be contraindicated. The development of tuberculous meningitis and the probably permanent neurologic sequelae in the patient discussed bespeak the dangers at hand. With the antecedent history of fever, 70 pound weight loss, abdominal pain and a miliary pattern on the chest roentgenogram, it was appropriate to think in terms of tuberculous etiology although disseminated histoplasmosis or, rarely, sarcoidosis¹ may occur with similar findings.

Furthermore, it is unique that the patient discussed in this report had radiographically documented, untreated miliary tuberculosis for more than three months, received antituberculosis therapy for only ten days, and fortunately survived for another two months. Although documented reports of prolonged survival with untreated miliary tuberculosis exist,²⁻⁵ in general it has been unusual for patients to survive for more than four to six weeks from the asymptomatic onset.⁴ This man not only survived with essentially untreated miliary tuberculosis, but he did so while receiving corticosteroids—drugs which result in the suppression of the cellular immune response and other important host defense mechanisms.

On the other hand, it must be

recognized that noncaseating granulomas of the peritoneum resulting from *M. tuberculosis* are very uncommon. Fedotin and Brewer have recently recorded two cases and point out the failure to previously document this pathological entity in the literature. They point out that prior studies of peritoneal tuberculosis,⁶⁻⁸ by requiring caseating granulomas, positive cultures for *M. tuberculosis*, or demonstration of acid-fast bacilli to satisfy diagnostic criteria, have thus excluded noncaseating granulomas as a potential histology variant. The present case is, therefore, the third report of noncaseating peritoneal granulomas resulting from tuberculosis, but it differs from the cases of Fedotin and Brewer in that it clearly occurred in association with miliary tuberculosis and no mycobacteria were recovered from the granulomas. *M. tuberculosis* were, however, isolated from gastric and cerebrospinal fluids.

The usual presenting complaint in a case of peritoneal tuberculosis is abdominal distention, usually with chronic tenderness and pain which may be sufficiently acute to mimic cholecystitis, appendicitis, or pelvic inflammatory disease⁹ resulting in laparotomy, as noted in the present case. Most authors have agreed for many years that the so-called "doughy" abdomen of tuberculous peritonitis is unreliable, uncommon and overemphasized as a diagnostic sign.^{3, 7-10} Ascites is usual, but is by no means universal. For example, in one study⁷ five of 32 patients did not have clinical ascites except on laparotomy. Tuberculous peritonitis may be easily overlooked in patients with hepatic cirrhosis and ascites, especially since there may be no fever; the chest roentgenogram may be normal, and the tuberculin skin test may be negative. Fever is usual, and not uncommonly an abdominal mass may be present as a result of adherent bowel and omentum.

Most cases of peritoneal tuberculosis represent disseminated or miliary forms of tuberculosis as exemplified by the present case and as suggested by others.⁷⁻⁹ Approximately one-third of these patients have evidence of pulmonary tube

culosis, often of the pleuritic type.^{7, 8} However, a normal chest roentgenogram is common despite recovery of tubercle bacilli from sputum antemortem or at autopsy in miliary tuberculosis.³

It is not surprising that the tuberculin skin test has varying positivity, depending on the duration and severity of the tuberculous disease. In a prior study of miliary tuberculosis by this author³ only 52 percent of the patients had positive tuberculin reactions to the equivalent of 5 TU of PPD-S; similarly, studies of peritoneal tuberculosis have recognized a high degree of tuberculin negativity.^{5, 6, 11}

In summary, this patient had an occult illness, a negative tuberculin skin test, a normal chest roentgenogram, no ascites, and noncaseating

granulomas on peritoneal biopsy which were negative on stain and culture for mycobacteria, and yet he had tuberculous peritonitis in association with miliary tuberculosis.

SUMMARY

The rare occurrence of noncaseating granulomas of the peritoneum caused by *M. tuberculosis* was determined in a patient who had miliary tuberculosis. This unusual entity and its diagnostic pitfalls have been exemplified and discussed. Unusual also was the well-documented, prolonged survival (for more than five months) with essentially untreated miliary tuberculosis culminating in tuberculous meningitis.

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When you have not a scientific demonstration of the facts, always say, in giving your opinion, that you do not know. Not only will you be speaking the truth, but it is much better to say at the preliminary examination, "I do not know," than to be forced at the trial to say, "I did not know."—*Death and Sudden Death*, P. Brouardel, 1897, p. 20.

A Five-Year Study of Uric Acid, Cholesterol, and Selected Fitness Variables in Professional Men

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EVIDENCE has accumulated which links serum cholesterol (SC) with cardiovascular disease. No lipid or battery of lipids appears to be more useful than an accurate SC value for the purpose of predicting coronary heart disease (CHD) in men and young women. This is true despite uncertainty concerning the regulation of cholesterol in the body, its optimal range of values, details of its involvement in pathogenesis, and its determinants within populations.¹ For instance, there is no "normal" SC reading, but risk appears to increase exponentially as SC rises in linear fashion. A person with an SC of 260 mg/dl is at an approximately five times greater risk than one whose SC is 200 mg/dl. Those people having readings higher than 400 mg/dl rarely live to the age of fifty.²

Recent research has provided some elegant explanations of the *modus operandi* by which cholesterol may promote atherogenesis. Shimamoto and his colleagues³ have

extended the findings of Anitschkow⁴ who produced experimental atherosclerosis by daily oral administration of cholesterol to rabbits. A single dose of cholesterol appears to permit infiltration of substances such as lipoproteins,³ fibrinogen,⁵ and cholesterol⁶ into the subendothelial space and medial layers of an artery. The platelet-repelling function of endothelial cells is also reduced,⁷ thus initiating viscous metamorphosis.

Studies of SC levels, after patients had a strenuous bout of exercise, have presented conflicting findings — some indicating increases⁸⁻¹⁰ and others indicating no change.^{11, 12} Chronic (long-term) physical training, however, appears to be capable of lowering SC, provided that the SC level is high at the start of the program and that the exercise is sufficiently vigorous.^{13, 14}

Systems for uric acid regulation are clinically relevant in man because excessive retention can lead to the precipitation of crystals which may initiate acute and chronic gouty arthritis¹⁵ and may be related to systolic blood pressure¹⁶ and hypertension.^{17, 18} In addition, some studies of patients with known CHD showed that these patients had high-

er levels of serum uric acid (SUA) than SC.^{19, 20} Finally, Moore and Weiss²¹ suggest that uric acid may damage the vascular intima, predisposing it to cholesterol deposition.

An association has been reported between hyperuricemia and hypercholesterolemia.^{22, 23} Pincherle²⁴ has suggested that the association of hyperuricemia with increased level of coronary thrombosis is attributed to their common association with raised SC levels. This association is also indicated by the Framingham study²⁵ which yielded a significant relationship between gouty arthritis and CHD. Kohn and Prozan²² concluded that hyperuricemia appears to be a concomitant of myocardial infarction with approximately the same degree of frequency as hypercholesterolemia. The work of Schoenfeld and Goldberger²³ lends further support to the supposition of a fundamental link between the substances; they report a positive correlation between absolute level and the direction and magnitude of diurnal change in SC and SUA levels. Gertler and associates²⁶ attempted to clinically apply this apparent relationship by incorporating SUA levels into a ratio with SC levels and phospholipid levels. The

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purpose was to assess individual HD risk.

The increase in SUA resulting from a strenuous bout of exercise has been well documented.²⁷ Changes in SUA with training are inconsistent. Studies have shown increases,²⁸ decreases,²⁹ and no change.³⁰

The purpose of the present study was to examine the effects of training on SC, SUA and selected fitness variables in professional men during a five-year longitudinal exercise program. The interrelationships of these variables were also examined.

PROCEDURE

The exercise program was initiated in October 1961 as a service to the community, and although research is secondary to this original purpose, two papers^{31, 32} have reported findings from subsequent investigations. All variables, except the 1.5 mile run and SUA, were assessed from the beginning. The 1.5 mile run was begun in 1968 and the SUA collection in 1967, the year in which the present study was initiated. Calisthenics of high duration and intensity comprised the exercise program during the first three years. Jogging was introduced in the fourth year, and the duration and intensity of calisthenics were lowered accordingly.

Thirty-one professional men were selected for the study. Five were released from the program because of medication which had been prescribed for them affects SC and SUA. The remaining 26, from the ages of 36 to 70, included businessmen, bankers, lawyers, professors, auditors, physicians, dentists and government officials. They participated in three formal exercise sessions each week for nine months in each of five years (1967 to 1972). The exercise sessions were conducted on a gradually progressive basis by trained instructors, and included calisthenics, rope skipping and bench stepping. In addition, all subjects ran or jogged for at least 30 minutes, twice and usually three or more times weekly. Subjects exercised on an individual basis during summer months. All exercise repetitions

and running mileage were recorded on individualized forms kept in a locker room file. The following data were obtained in the fall, winter and spring of each year: height, weight, body fat measured by skinfolds, 1.5 mile run time, bent knee sit-ups, chin-ups, lateral jump over a 15-inch rope, resting pulse, pulse after three-minute modified Harvard step test on a 17-inch bench, SC, and SUA.

Skinfolds were assessed by the method of Brozek and Keys³³ and converted to percent body fat by the Rathbun and Pace formula.³⁴ The 1.5 mile run was completed on a quarter-mile track. Bent knee sit-ups, chin-ups, and lateral jumps were the maximum number that could be achieved. Resting heart rate was recorded in the supine position after a five-minute rest prior to the modified Harvard test. From antecubital blood samples, both the SC and SUA were calculated with standard colorimetric methods³⁵⁻³⁷ by means of a Technicon Auto Analyzer at Rex Hospital chemistry laboratory.

Coefficients of variation for the six-year period, 1967-1972, inclusive, were calculated to be four percent and 1.7 percent for SC and SUA, respectively.

RESULTS AND DISCUSSION

Group SC values decreased from fall to spring in every year but 1971-1972 (Table 1). The increase in 1971 may be related to an aging effect; that is, the liver is known to metabolize lipids less effectively with age.³⁸ Further indication of the effects of age is provided by the significant ($P < 0.01$) correlation

between SC and age (Table 2). Although the rise in SC with age is well known, most studies show a plateauing near the age of 50, which may be the result of a survivor effect. That is, men with high SC and a high coronary risk tend to die earlier, thus reducing the mean cholesterol of the survivors.²⁴ Some research^{39, 40} has shown that participation in regular, vigorous exercise may possibly help in resisting this natural tendency of SC to increase with age. It is possible, in this respect, that a training effect may have been obscured, in the present study, by individual differences in time of entrance into the program. For instance, ten subjects had participated in the program for six years prior to the start of the program, and five entered the program in 1967. However, in this context, all group SC means except two (fall and winter, 1969-1970) were lower than the initial group mean of 237 mg/dl (Table 1).

Similar results appear in Table 3 which lists annual group values. Previous studies of men in the North Carolina State Fitness Class have shown significant decreases in SC with training³¹ and have indicated that their SC was lower than usual for men in the fourth and fifth decades.³² Scrutiny of individual data yields findings similar to those of Golding³⁹ who observed reductions in SC during the first, second and third years. During the fourth and fifth years, however, the SC level increased. A plateau was achieved in the sixth year and, although it had increased, it was still significantly below original levels. A secondary reduction occurred in the seventh

Table 1
Group Five-Year Seasonal SC and SUA Values

	Fall		Winter		Spring	
	SC	SUA	SC	SUA	SC	SUA
1967-68	199	7.00	204	6.50	195	6.91
1968-69	229	6.66	212	6.62	214 ^a	6.94
1969-70	239	6.57	247	6.32	226 ^a	6.26
1970-71	212	6.62	216	6.21	207	6.74
1971-72	209	7.50	219	6.62	220 ^b	6.62 ^a

Group mean SC upon entry to program = 237 mg/dl
Group mean SUA at first measurement = 7.00 mg/dl

a. $P < 0.01$ for difference from fall value.

b. $P < 0.05$ for difference from fall value.

Table 2
Five Year Correlations

	WEIGHT	HT √WT	BODYFAT	CHINS	JUMPS	SITUPS	1.5M RUN	STEP TEST	T-SCORE	REST PULSE	SC	SUA
AGE	-0.359 ^a	-0.124 ^b	0.243 ^a	-0.359 ^a	-0.272 ^a	-0.257 ^a	0.616 ^a	0.505 ^a	-0.414 ^a	0.133 ^a	0.211 ^a	0.18
TIME IN PROGRAM	-0.266 ^a	-0.044	-0.168 ^a	0.130 ^a	-0.348 ^a	0.152 ^a	0.123 ^b	0.106 ^b	0.232 ^a	-0.015	0.201 ^a	0.2
HEIGHT	0.690 ^a	0.205 ^a	-0.106 ^b	0.077	0.131 ^a	0.169 ^a	-0.418 ^a	-0.410 ^a	0.204 ^a	-0.288 ^a	-0.169 ^a	-0.0
WEIGHT		-0.091	0.303 ^a	-0.182 ^a	-0.063	-0.210 ^a	-0.313 ^a	-0.169 ^a	-0.062	-0.238 ^a	-0.044	-0.0
HT √WT			-0.125 ^b	-0.005	0.161 ^a	0.217 ^a	0.056	-0.138 ^a	0.105	0.013	0.282 ^a	0.6
BODYFAT				-0.602 ^a	-0.509 ^a	-0.495 ^a	0.447 ^a	0.492 ^a	-0.619 ^a	0.198 ^a	0.179 ^a	0.1
CHINS					0.508 ^a	0.385 ^a	-0.361 ^a	-0.280 ^a	0.757 ^a	-0.094	0.048	0.1
JUMPS						0.499 ^a	-0.555 ^a	-0.420 ^a	0.774 ^a	-0.222 ^a	-0.011	0.0
SITUPS							-0.421 ^a	-0.519 ^a	0.680 ^a	-0.243 ^a	-0.183 ^a	-0.1
1.5 M RUN								0.563 ^a	-0.596 ^a	0.321 ^a	0.371 ^a	0.1
STEP TEST									-0.566 ^a	0.582 ^a	0.304 ^a	0.2
T-SCORE										-0.216 ^a	-0.073	0.0
REST PULSE											0.049	0.1
SC												0.2

^a P < 0.01

^b P < 0.05

year, coinciding with the national interest in jogging and the program's addition of increased running.

Pincherle²⁴ witnessed seasonal variations in SC. Values were highest in the winter, fell during the spring, reached minimum in the summer, and rose again in the fall. A similar trend, which may be attributable to an inverse relationship between SC and air temperature, is seen in the present study during 1967-1968, 1969-1970, and 1970-1971.

The changes in SUA from fall to spring (Table 1) were not as consistent as those exhibited by SC. This lack of consistency, however, may be spurious. For example, all blood samples were obtained in the post-absorptive state, and Ogryzlo⁴¹ has

shown that, in the fasting patient, uric acid excretion diminishes on the first day. Observations of diurnal variation in uric acid excretion show that the normal increase in excretion which occurs during the afternoon period disappears completely if the morning and noon meals are omitted⁴²⁻⁴⁴. A decreased excretion of uric acid can therefore be detected within 12 hours of commencing a fast; this effect has been attributed to the mobilization of fatty acids and a consequent ketonuria. The effects of a high fat diet are comparable, although less dramatic. No attempt was made to control diet in this study. As mentioned previously, SUA analysis was not initiated until 1967. Therefore, some training effects may have been obscured. Every

group mean except one (fall 1971-1972) is lower than the initial group value of 7 mg/dl, the value also considered hyperuricemic in males.⁴⁵

The professional responsibility of all subjects involved executing and administrative duties which required the subjects to make decisions and meet deadlines. This requirement is relevant in that most previous studies have shown SUA levels to be highest in well-educated professionals or executives.⁴⁶⁻⁴⁸ Brooks and Mueller⁴⁸ suggest that the high values of SUA observed in these people are related to the drive and competitive nature. The influence of psychologic stress has also been noted on SC, having been observed in patients following a stressful interview,⁴⁹ accountants before tax deadlines,⁵⁰ and in medical students at examination time.⁵¹

Subjects were then divided into subgroups (Tables 4-7) for purposes of more detailed analysis. The first four groups were formed with the criteria of training frequency, running mileage, observed motivation and physical fitness test performance. Group five was composed of four postcoronary subjects and one who had angina pectoris. Table 4, with three exceptions, shows decreases for every subgroup from fall to spring in the first four years of the study. During 1971-1972, however, increases in SC were present in every group, similar to changes

Table 3
Annual Group Profiles

	1967-1968	1968-1969	1969-1970	1970-1971	1971-1972
Age (months)	47.8 ± 7.4	48.4 ± 7.2	49.5 ± 7.2	50.5 ± 7.2	51.4 ± 7.2
Months in Program	49 ± 26	56 ± 30	69 ± 30	80 ± 30	92 ± 30
Height	69 ± 3	69 ± 3	69 ± 3	69 ± 3	69 ± 3
Weight	168 ± 21	170 ± 20	170 ± 20	171 ± 20	171 ± 20
Ponderal Index	12.35 ± 1.30	12.31 ± 1.24	12.30 ± 1.24	12.30 ± 1.23	12.29 ± 1.24
Bodyfat	7.5 ± 3.3	8.4 ± 3.2	8.2 ± 3.0	8.3 ± 3.1	7.9 ± 2.8
1.5m run (minutes)	not employed	11.4 ± 2.6	11.5 ± 2.5	11.4 ± 2.3	11.8 ± 2.6
Step Test	51 ± 10	47 ± 11	48 ± 10	47 ± 10	47 ± 11
T-Score	62 ± 15	62 ± 15	63 ± 15	66 ± 12	67 ± 13
Rest Pulse	30 ± 3	29 ± 5	29 ± 4	29 ± 4	29 ± 4
SC	199 ± 33	218 ± 40	237 ± 43	212 ± 38	216 ± 42
SUA	6.83 ± 1.24	6.74 ± 1.35	6.38 ± 1.29	6.52 ± 1.29	6.91 ± 1.45
Group mean SC upon entry to program = 237 mg dl					
Group mean SUA at first measurement = 7.00 mg dl					

exhibited by the group mean discussed previously. These changes may result from a change in the SC standards employed in the Rex Hospital chemistry laboratory. Figure 1 appears to provide some support for this contention. Comparison of mean SC values of each group upon entrance into the program with spring values of each year — those most likely to reflect the effects of training — yields only two spring values higher than those initially obtained. Further examination of Tables 4 and 5 shows that the three most active groups (1-3) exhibited lower SC than groups 5 and 6 in all testing periods while group 4, the least active, presented the highest SC and SUA of all groups in every testing period except one (i.e., winter 1968-1969, group 5 SC was higher than that of group 4). This same pattern is reflected in the five-year seasonal values (Table 6). These data appear to dramatize the efficacy of exercise in controlling SC and SUA.

Correlations (Table 2) between SUA and age, time in program, step test, resting pulse, chin-ups, and SC were significant at the 0.01 level. Body fat, sit-ups, and 1.5 mile run were related to SUA at the 0.05 level. Significant correlations

($P < 0.01$) were also observed between SC and age, time in the program, height, ponderal index, body fat, sit-ups, 1.5 mile run and step test.

The significant positive relationship between SC and SUA is in

agreement with findings from previous research with coronary patients,^{22, 26} hypercholesterolemia,⁵² stress,⁵³ and gout.⁵⁴ Klein's study⁴⁵ of 2,530 white and black males and females, however, presents

Table 4
Subgroup Yearly Seasonal SC Changes

Year	Subgroup	Entrance SC	Fall	Winter	Spring
1967-68	1	236	192	197	184
	2	201	184	170	162
	3	202	187	195	196*
	4	278	226	247	231*
	5	281	214	219	207
1968-69	1	236	230	213	209
	2	201	188	176	177
	3	202	204	195	204†
	4	278	272	231	245
	5	281	253	252	236
1969-70	1	236	225	241	217
	2	201	204	210	196
	3	202	227	238	210†
	4	278	286	285	263
	5	281	257	274	248
1970-71	1	236	196	207	198*
	2	201	183	184	179
	3	202	198	197	193
	4	278	257	252	245
	5	281	231	243	223
1971-72	1	236	192	210	209*
	2	201	179	182	188*
	3	202	191	201	201*
	4	278	253	269	264*
	5	281	236	239	241*

* Higher than fall value.

† Higher than entrance SC value.

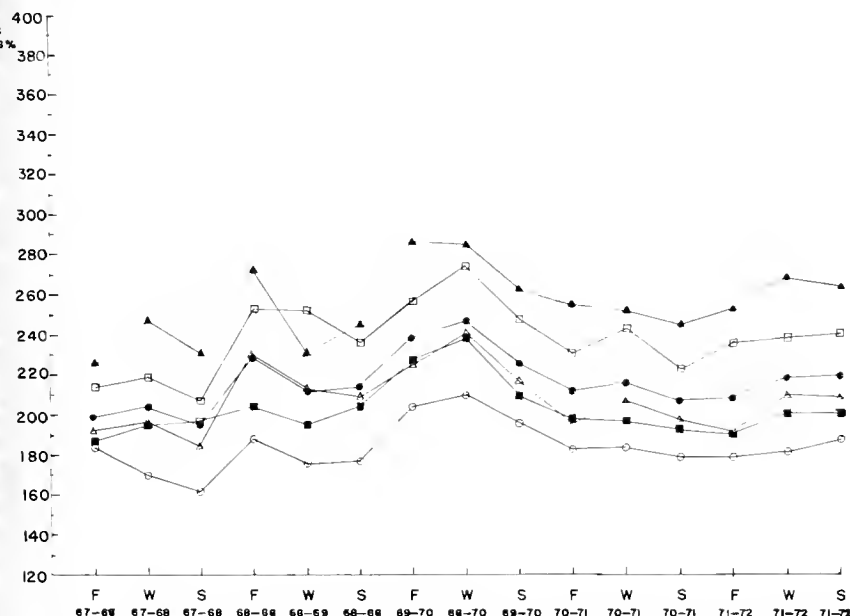


Fig. 1. Subgroup SC seasonal fluctuations. Subgroup 1: Δ — Δ ; Subgroup 2: \circ — \circ ; Subgroup 3: \square — \square ; Subgroup 4: \diamond — \diamond ; Subgroup 5: \times — \times ; Group mean: \bullet — \bullet .

Table 5
Subgroup Yearly Seasonal SUA Changes

Year	Subgroup	Fall	Winter	Spring
1967-68	1	6.63	6.95	6.80
	2	6.60	5.43	6.50
	3	6.92	6.47	7.16
	4	8.78	7.54	8.00
	5	6.83	5.88	6.08
1968-69	1	6.80	6.10	7.65
	2	6.07	6.18	6.04
	3	6.58	6.77	7.08
	4	8.09	7.80	8.40
	5	5.93	6.48	5.69
1969-70	1	6.55	5.64	6.07
	2	6.35	5.93	5.86
	3	6.73	6.61	6.47
	4	7.19	8.18	7.30
	5	6.09	5.31	5.72
1970-71	1	6.46	6.18	6.52
	2	5.95	5.56	5.90
	3	6.68	6.28	7.10
	4	8.41	7.60	7.70
	5	5.79	5.60	6.28
1971-72	1	7.20	6.22	6.02
	2	6.92	5.72	5.82
	3	7.06	6.68	6.75
	4	9.33	8.40	8.68
	5	7.06	6.44	6.14

Table 6

Subgroup Five Year SC and SUA Seasonal Values

Subgroup	N	Fall		Winter		Spring	
		SC	SUA	SC	SUA	SC	SUA
1	6	207	6.73	214	6.22	203	6.61
2	5	188	6.37	185	5.78	181	6.00
3	6	202	6.79	205	6.57	201	6.90
4	4	259	6.49	256	7.90	205	8.02
5	5	239	6.32	247	5.92	232	5.98

Table 7

Subgroup Five Year Profiles

	Subgroup 1	Subgroup 2	Subgroup 3	Subgroup 4	Subgroup 5
Age (months)	44.3 ± 4.4	48.3 ± 3.8	47.3 ± 2.3	59.5 ± 6.8	51.6 ± 7.6
Months in	73 ± 32	65 ± 27	48 ± 29	98 ± 17	63 ± 36
Height	71 ± 2	71 ± 2	68 ± 4	68 ± 2	68 ± 1
Weight	175 ± 18	181 ± 18	174 ± 26	164 ± 22	158 ± 12
Ponderal Index	12.78 ± .45	11.61 ± 2.27	12.24 ± .24	12.40 ± .19	12.50 ± .37
Bodyfat	5.5 ± 3.0	9.3 ± 1.8	8.4 ± 2.5	10.4 ± 2.7	8.6 ± 2.6
Chinups	14 ± 4	11 ± 3	9 ± 3	9 ± 5	11 ± 3
Vertical Jumps	109 ± 38	63 ± 23	61 ± 28	53 ± 18	47 ± 14
Situps	162 ± 102	107 ± 55	76 ± 33	57 ± 24	96 ± 49
1.5m run (minutes)	9.1 ± .7	10.8 ± .5	11.5 ± .6	14.1 ± 1.1	13.8 ± 3.0
Step test	39 ± 7	48 ± 6	45 ± 8	61 ± 7	52 ± 7
T-Score	76 ± 10	65 ± 10	59 ± 12	54 ± 14	61 ± 10
Rest pulse	27 ± 2	29 ± 3	29 ± 2	31 ± 6	30 ± 4
SC	204 ± 30	197 ± 33	192 ± 35	255 ± 44	239 ± 32
SUA	6.40 ± 1.06	6.62 ± 1.36	6.33 ± 1.06	8.09 ± 1.33	6.07 ± .95

data showing no significant relationship between these variables. These same investigators also made observations regarding SUA and age. They suggest that several factors are involved with significant roles probably being played by changes in dietary habits and physical activity. These findings are at variance with Montoye et al⁵⁵ who concluded, as a result of their study of 167 business executives ranging in age from 30 to 59 years, that SUA is not related to age. Mikkelsen et al⁵⁶ present similar results.

The inverse relationship between height and SC duplicates the findings of Pincherle.²⁴ As a result of his findings, he postulates that the greater coronary risk observed in short people may be accounted for by their common relationship with SC. The lack of association observed between ponderal index and SUA is at variance with results from previous research by Gertler et al²⁶ and Klein et al⁴⁵ who reported a significant association between increased ponderosity and hyperuricemia. The relationship between SC and body fat is well documented.^{57, 58} Indeed,

previous studies indicate an associated rise of serum lipids with weight gain⁵⁹ and a decrease concomitant with a decrease in weight.⁶⁰ Strong correlations between SUA and measures of body weight,^{61, 62} obesity,⁶³ and body size²⁶ also have been reported.

CONCLUSIONS

1. The chronic effect of regular, vigorous exercise is a decrease in both SC and SUA concentrations.

2. There is a relationship between SC and SUA concentrations.

3. Serum cholesterol and SUA concentrations are age-related.

4. Serum cholesterol concentration varies with body fat, as does SUA concentration to a lesser degree.

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To the medical jurist the study of the causes of death, of the phenomena which precede the examination of the corpse, is of great importance; in more than half of the medico-legal examinations that you will be called upon to make, whether the question raised is one of suicide, murder, sudden death, or survivorship, it is with the study of the dead body that you will have to begin.

Activity does not entirely cease at the instant of death. Vital phenomena are replaced by cadaveric phenomena: it is requisite that you should become familiar with these last, for inexperienced medical men have ascribed to poisoning lesions which have been really produced after death by the normal processes of decomposition.—*Death and Sudden Death*, P. Brouardel, 1897, p. 2.

Editorials

CARDIAC CATHETERIZATION IN THE NEWBORN

It is a well known fact that during the past four decades, cardiac surgery has made tremendous strides in correcting inborn anomalies of the child. Much less has been said, however, about the large percentage of those children born with hemodynamically significant cardiac disease who die within the first 12 months of life because either the complexity of the anomaly or the small size of the patient made surgical intervention inadvisable.

Having now reached a point when more and more complex congenital cardiac lesions are falling prey to the advancement of medical and surgical management, the days of benign neglect and watchful waiting for the newborn in cardiac distress have passed. To interrupt the sorrowful train of cardiac deterioration, which most of the time leads to the demise of these unfortunate children, the following steps are mandatory:

- (1) Consider the possibility of congenital heart disease in the newborn in cardiopulmonary distress.
- (2) Establish an accurate diagnosis using all necessary means, including cardiac catheterization.
- (3) Institute medical or surgical therapy, or both, as soon as possible.

It is evident that the primary physician, who sees the newborn after delivery and who follows him during the first days and weeks of life, holds the key position in this process.

When should we consider the necessity of hemodynamic studies? The principal indication for such studies in the newborn and very young infant is congestive heart failure or cyanosis, or both, usually caused by one of the following conditions: hypoplastic left heart including coarctation of the aorta, transposition of the great vessels, obstruction to the pulmonary flow, and large left-to-right shunts.

The clinical appearance of the newborn with a *hypoplastic left heart* is one of shock secondary to poor cardiac output. This may be confused with hypovolemia, sepsis or adrenal insufficiency. The clinical constellation is one of congestive failure, poor peripheral pulses in both the upper and lower extremities, mottled appearance of the skin and a large heart on roentgenographic examination. Since the outcome for these infants is almost uniformly fatal, they should be studied primarily to rule out other correctable conditions.

Symptomatic *coarctation of the aorta* in the new-

born period usually implies the presence of associated intracardiac pathology, e.g., left heart hypoplasia and endocardial fibroelastosis or a ventricular septal defect. The well known clinical "giveaway" is the absence of pulses in the lower extremities. Newborns suspected of having aortic coarctation should undergo catheterization for congestive heart failure, with or without response to medical therapy, if left ventricular outflow obstruction is present. Since this is an extracardiac lesion, it may be repaired even in the newborn period if indicated by closed heart surgery.

Transposition of the great vessels is an anomaly second in frequency only to hypoplastic left heart as a cause of heart failure in the newborn. In this disease congestive failure and cyanosis are usually present. The patient seldom has a significant murmur; the chest roentgenograms may or may not demonstrate the typical findings of an egg-shaped heart with increased pulmonary vascularity, and the electrocardiogram may be within the range of the normal for a newborn. These children frequently present a problem as to whether their cyanosis is cardiac or otherwise, e.g., pulmonary. The adjunct of blood gas determinations can be helpful in this regard; persistently low arterial pO_2 while the infant breathes 100 percent oxygen indicates a large right-to-left shunt which is usually intracardiac. This simple laboratory test lends support to the old clinical observation that the newborn with pulmonary disease usually "pinks up" while oxygen is being administered, in contrast to the "cardiac-baby," who does not. Infants suspected of transposition should be immediately referred to the cardiologist, not only because catheterization is diagnostic but also because balloon atrial septostomy done during catheterization can be lifesaving for these children.

The primary symptom in newborn infants with *obstruction to pulmonary blood flow* is cyanosis, but congestive heart failure also may occur. The latter, however, is less frequent than in transposition. Anatomically, they may have tetralogy of Fallot, atresia of the pulmonary artery, significant valvular pulmonic stenosis with intact ventricular septum or tricuspid atresia. On roentgenographic examination the child's heart is usually small and the lung field appear normal or avascular. The electrocardiogram except in those patients suffering from a hypoplastic right heart (tricuspid atresia or pulmonary atresia with intact ventricular septum), shows right ventricular preponderance. Infants belonging to the "low pul-

monary flow" group should undergo cardiac catheterization in order that their cardiac anatomy be delineated and the necessity and feasibility of curative or palliative surgery be studied.

Left-to-right shunts are less frequent causes of cardiac distress in the immediate newborn period, but they may be present in the first few weeks or months of life, when the pulmonary vascular resistance declines. Atrial septal defects are rarely present with congestive heart failure; however, one out of ten infants with a ventricular septal defect develops congestive failure, usually at six to eight weeks of age. A patent ductus arteriosus in the newborn or infant may mimic closely a ventricular septal defect with the diastolic component of the continuous murmur entirely missing. A history of prematurity, neonatal respiratory distress or maternal rubella suggests the presence of a patent ductus arteriosus. The common denominator of increased pulmonary blood flow, regardless of the site of the shunt, may be demonstrated on the chest film.

Cardiac distress in the newborn caused by a left-to-right shunt should be treated promptly and ener-

getically with appropriate drugs. If the infant fails to respond adequately to medical therapy, cardiac catheterization should be done without delay, since a number of anomalies belonging to this category can be dealt with effectively by corrective or palliative surgery. There is nothing more tragic than to lose an otherwise healthy child from an overlooked or misdiagnosed patent ductus arteriosus, which can be repaired with a minimal operative risk.

This sketchy overview is intended to assist primary physicians in their decision as to when to refer very young infants for cardiac catheterization. Although the risk of mortality and morbidity from hemodynamic studies is extremely low in both the adult and the child, it may be appreciable in the newborn in severe cardiopulmonary distress. In spite of this somewhat increased risk, the procedure should be performed without hesitation if the necessity arises. Not doing so would deny the benefits of an accurate diagnosis and effective medical or surgical management of a child born with a cardiac defect who may be salvageable.

ROBERT D. JACKSON, M.D.

Correspondence

Changes in Commitment Laws

To the Editor:

I read with interest the article by Drs. Raft, Werbaan and Spencer, "To Commit or Not to Commit, the Continuing Dilemma: Some Guidelines," in the September issue of the JOURNAL. It is an interesting article, and in many ways illuminating.

Your readers should know, however, that the admissions statutes quoted and explained were replaced by the 1974 Session of the General Assembly, with important modifications in procedure. Judicial commitment now is initiated, not by a law enforcement officer, but rather by a relative or other person who files an affidavit with a magistrate or clerk of court, stating that the person is believed to be mentally ill, or inebriate, and imminently dangerous to himself or to others. The clerk or magistrate may then issue an order for a law enforcement officer

to take the person into custody for examination by a physician. Subsequent events are similar to those that took place under the 1973 Act. It should also be noted, however, that the term "gravely disabled" has been eliminated. A part of the definition of "danger to self or others," is that the person is unable to "provide for basic personal needs for food, clothing or shelter."

The emergency procedure described in the article remains in force essentially as described, but can be invoked by a law enforcement officer only if a person is "violent and requires restraint, and delay in taking him to a qualified physician for examination would likely endanger life or property. . . ." The clerk or magistrate may then order the person taken directly to a mental health facility (State of North Carolina Session Laws, 1973 (Second Session 1974), Chapter 1408, Senate Bill 981).

The law governing voluntary admissions was changed also by the 1974 Legislative Session, but does not invalidate the comments included in the article.

It is essential that North Carolina physicians be cognizant of the laws governing admissions to mental health facilities, and also of some practical consequences of statutory changes. The authors' case report and comments remain valid and offer valuable insight into the clinical management of various de-

grees of behavior disorders, and the way in which such management is affected by the relevant statutes.

N. P. ZARZAR, M.D., *Director*

Mental Health Services

North Carolina Department of Human Resources

Division of Mental Health Services

Albemarle Building

325 N. Salisbury St.

Raleigh, North Carolina 27611

Emergency Medical Services



ALTERNATIVE TO "911"

William J. Henry, M.D.

Twisp Medical Center

Twisp, Washington

In order to gain entry into the emergency medical systems, the "911" concept has been introduced in large metropolitan areas. This gives the caller the ability to talk to a central dispatcher for fire, police, ambulance or physician.

In rural areas, primarily because of the expense, the "911" concept has been impractical. In a rural community in north central Washington, a system has been installed using the number 7111. Five telephones were installed answering to this number: one at the medical center, one at a physician's home, one at a registered nurse's home, and two in ambulance attendants' homes. The list of on-call physi-

cians, ambulance attendants and nurses is available so that rapid response can be obtained.

Installation charges were approximately \$150.00 and the monthly service charges are about \$25.00. This has been paid for from gifts from the community. In the two and one-half months since its installation, the community has been pleased with the practicality and operational aspect of the system. With continued publicity, it is anticipated that its use will increase.

—Abstracted by George Johnson, Jr., M.D.

From "Emergency Medicine Today," Vol. 3, No. 9, September 1974, John M. Howard, M.D., Editor. Original article may be obtained from Commission on Emergency Medical Services, American Medical Association, 535 North Dearborn Street, Chicago, Illinois 60610.

Bulletin Board

NEW MEMBERS of the State Society

uchanan, Robert Augustus, Jr., MD (CD), 1200 Broad St., Durham 27705
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 Culley, James Paul, MD (GS), 506 Wood St., Troy 27371
 Earnest, Robert Rhea, MD (PD), 2436 Asheville Rd., Waynesville 28786
 Hernandez, Hector Rene, MD (Intern-Resident), 1036 Lakeside Dr., Rt. 8, Durham 27704
 Nottingham, Thomas Eliot, MD (PD), Box 3937, Duke Med. Ctr., Durham 27710
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 West, Howard Ryland, Jr., MD (AN), 529 Edgewood Rd., Asheboro 27203

WHAT? WHEN? WHERE? In Continuing Education

December 1974

Note: (1) Programs sponsored by the Bowman Gray, Duke or UNC Schools of Medicine are approved for "Category 1" AMA Physician Recognition Award credit, and for AAFP "Prescribed" continuing education credit when such

approval has been granted by the AAFP. (2) "Place" and "sponsor" are indicated below only where these differ from the place and group or institution listed under "For information."

Programs in North Carolina

January 22-24

North Carolina's Alcoholism Awareness Week—1975

Place: Sheraton Crabtree Motor Inn, Raleigh

Sponsors: N. C. Alcoholism Research Authority, N. C. Center for Alcohol Studies at UNC-Chapel Hill; N. C. Department of Human Resources, N. C. Jaycees; N. C. State Medical Society, N. C. Neuro-Psychiatric Association

Program: Respective topics for the three days will be as follows: 22nd—Medical Health for the Alcoholic. At 7:30 p.m. Mrs. Marty Mann, founder of the National Council on Alcoholism, will speak in Christ's Episcopal Church, Raleigh, on "Alcoholism and You." 23rd—Alcoholism—The Search for the Sources. At the 7:00 p.m. banquet the main address will be given by Secretary David Flaherty, N. C. Department of Human Resources. 24th—First Annual North Carolina Alcoholism Researchers' Forum

Fee: \$30 in-state; \$45 out-of-state. Pre-registration by January 7 is requested

Credit: 13 hours AAFP continuing education credit applied for

For Information: John A. Ewing, M.D., Executive Secretary, Alcoholism Research Authority, 623 E. Franklin Street, Chapel Hill 27514

January 24-25

Surgical Infections

Fee: \$75

Credit: 12 hours

For Information: Emery C. Miller, M.D., Associate Dean for Continuing Education, Bowman Gray School of Medicine, Winston-Salem 27103

January 31-February 1

North Carolina Medical Society 1975 Conference for Medical Leadership

Place: State Society Headquarters Building, Raleigh

Program: Designed especially for Society Officers and other members who carry leadership responsibility. Open to all interested Society members.

For Information: Mr. William N. Hilliard, Executive Director, North Carolina Medical Society, P. O. Box 27167, Raleigh 27611

February 7-8

Current Topics in Occupational Health

Place: Carolina Inn, Chapel Hill

Sponsors: Dept. of Community Health Sciences, Duke University Medical Center; Carolina Industrial Medicine Association; N. C. Association of Industrial Nurses

For Information: Leonard J. Goldwater, M.D., Dept. of Community Health Sciences, Duke University Medical Center, Box 2914, Durham 27710

February 14-15

Medical Ethics Symposium

Place: Babcock Auditorium

Fee: \$30

Credit: 15 hours

For information: Emery C. Miller, M.D., Associate Dean for Continuing Education, Bowman Gray School of Medicine, Winston-Salem 27103

February 17-18

Regional Diabetes Teaching Nurse Workshop

Fee: \$50

For Information: Judith E. Wray, Administrative Secretary,
Continuing Education Program, UNC School of Nursing,
Chapel Hill 27514

February 19

Paraneoplastic Syndromes—the Wingate Johnson Memorial Lecture

Place: Babcock Auditorium, Time: 11:00-12:00 a.m.

Speaker: Prof. A. McGehee Harvey, M.D., Johns Hopkins Hospital, Baltimore, Maryland

For Information: Emery C. Miller, M.D., Associate Dean
for Continuing Education, Bowman Gray School of Medicine,
Winston-Salem 27103

March 3-4

Nutrition in Mothers, Infants, and Pre-School Children

Place: Carolina Inn, Chapel Hill

For Information: Dr. John J. B. Anderson, Department
of Nutrition, School of Public Health, UNC, Chapel
Hill 27514

March 12 & May 7

(two different workshops)

Toward More Effective Diabetic Teaching

Practical approaches to diabetic care, including some
newer developments and less well-known aspects

Place: March 12—Reidsville; May 7—Raleigh

Fee: \$20

For Information: Judith E. Wray, Administrative Secretary,
Continuing Education Program, UNC School of
Nursing, Chapel Hill 27514

March 17-21

Tutorial Postgraduate Course: Radiology of the Gastrointestinal Tract

Place: Governors Inn, Research Triangle Park (between
Durham and Raleigh, near the airport)

Program: Designed for radiologists, but open to other
physicians in training or practice. Emphasis on personal-
ized, tutorial type teaching, with ample opportunity for
discussion. Two 1 hour 20 minute tutorial sessions each
morning, and one in the afternoon; 12 registrants will
join one faculty member in a separate quiet room with
viewboxes for organized film reading-discussions and case
presentations. Each registrant will have a total of 14 dif-
ferent tutorial sessions. One hour "Panel" presentation-
discussion each afternoon. Guest faculty include: Drs.
Charles A. Bream, Harley C. Carlson, Joseph T. Fer-
rucci, Jr., Roscoe E. Miller, Jerry C. Phillips, Bernard S.
Wolf, and, from Kings College Hospital, London, Eng-
land, Dr. John Laws, Chairman, Department of Radi-
ology

Fee: \$300; enrollment limited

Credit: 28 hours AMA "Category One" accreditation

For Information: Robert McLelland, M.D., Department of
Radiology, Box 3808, Duke University Medical Center,
Durham 27710

March 25-26

Problem-Oriented Medical Record System

Through a video-tape simulated case presentation, par-
ticipants will be involved in learning to use the POMR
through actual involvement

Fee: \$50

For Information: Judith E. Wray, Administrative Secretary,
Continuing Education Program, UNC School of
Nursing, Chapel Hill 27514

March 27-28

The Nursing Audit

Designed to assist nursing administrative personnel in
evaluating the quality of patient care through the use of
a systematic auditing technique

Fee: \$50

For Information: Judith E. Wray, Administrative Secretary,
Continuing Education Program, UNC School of Nursing,
Chapel Hill 27514

April 4-5

Pediatric Postgraduate Course

For Information: Emery C. Miller, M.D., Associate Dean

Rondomycin

(methacycline HCl)

CONTRAINDICATIONS

Hypersensitivity to any of the tetracyclines

WARNINGS Tetracycline usage during tooth development (last half of pregnancy to eight years) may cause permanent tooth discoloration (yellow-gray-brown), which is more common during long-term use but has occurred after repeated short-term courses. Enamel hypoplasia has also been reported. **Tetracyclines should not be used in this age group unless other drugs are not likely to be effective or are contraindicated.**

Usage in pregnancy (See above **WARNINGS** about use during tooth development). Animal studies indicate that tetracyclines cross the placenta and can be toxic to the developing fetus (often related to retardation of skeletal development). Embryotoxicity has also been noted in animals treated early in pregnancy.

Usage in newborns, infants, and children (See above **WARNINGS** about use during tooth development).

All tetracyclines form a stable calcium complex in any bone-forming tissue. A decrease in fetal bone growth rate observed in premature given oral tetracycline 25 mg/kg every 6 hours was reversible when drug was discontinued.

Tetracyclines are present in milk of lactating women taking tetracyclines.

To avoid excess systemic accumulation and liver toxicity in patients with impaired renal function, reduce usual total dosage and if therapy is prolonged, consider serum level determinations of drug. The anti-anabolic action of tetracyclines may increase BUN. While not a problem in normal renal function, in patients with significantly impaired function, higher tetracycline serum levels may lead to azotemia, hyperphosphatemia, and acidosis.

Photosensitivity manifested by exaggerated sunburn reaction has occurred with tetracyclines. Patients apt to be exposed to direct sunlight or ultraviolet light should be so advised, and treatment should be discontinued at first evidence of skin erythema.

PRECAUTIONS If superinfection occurs due to overgrowth of nonsusceptible organisms, including fungi, discontinue antibiotic and start appropriate therapy.

In venereal disease, when coexistent syphilis is suspected, perform darkfield examination before therapy, and serologically test for syphilis monthly for at least four months.

Tetracyclines have been shown to depress plasma prothrombin activity; patients on anticoagulant therapy may require downward adjustment of their anticoagulant dosage.

In long-term therapy, perform periodic organ system evaluations (including blood, renal, hepatic).

Treat all Group A beta-hemolytic streptococcal infections for at least 10 days.

Since bacteriostatic drugs may interfere with the bactericidal action of penicillin, avoid giving tetracycline with penicillin.

ADVERSE REACTIONS **Gastrointestinal** (oral and parenteral forms): anorexia, nausea, vomiting, diarrhea, glossitis, dysphagia, enterocolitis, inflammatory lesions (with monilial overgrowth) in the anogenital region.

Skin: maculopapular and erythematous rashes, exfoliative dermatitis (uncommon). Photo-sensitivity is discussed above (See **WARNINGS**).

Renal toxicity: rise in BUN, apparently dose related (See **WARNINGS**).

Hypersensitivity: urticaria, angioneurotic edema, anaphylaxis, anaphylactoid purpura, pericarditis, exacerbation of systemic lupus erythematosus.

Bulging fontanels, reported in young infants after full therapeutic dosage, have disappeared rapidly when drug was discontinued.

Blood: hemolytic anemia, thrombocytopenia, neutropenia, eosinophilia.

Over prolonged periods, tetracyclines have been reported to produce brown-black microscopic discoloration of thyroid glands; no abnormalities of thyroid function studies are known to occur.

USUAL DOSAGE **Adults**—600 mg daily, divided into two or four equally spaced doses. More severe infections: an initial dose of 300 mg followed by 150 mg every six hours or 300 mg every 12 hours. **Gonorrhea**: in uncomplicated gonorrhea, when penicillin is contraindicated, Rondomycin (methacycline HCl) may be used for treating both males and females in the following clinical dosage schedule: 900 mg initially, followed by 300 mg q.i.d. for a total of 5.4 grams.

For treatment of syphilis, when penicillin is contraindicated, a total of 18 to 24 grams of Rondomycin (methacycline HCl) in equal, divided doses over a period of 10-15 days should be given. Close follow-up, including laboratory tests, is recommended.

Eaton Agent pneumonia: 900 mg daily, for six days.

Children—3 to 6 mg/lb/day divided into two to four equally spaced doses.

Therapy should be continued for at least 24-48 hours after symptoms and fever have subsided.

Concomitant therapy: Antacids containing aluminum, calcium or magnesium impair absorption and are contraindicated. Food and some dairy products also interfere. Give drug one hour before or two hours after meals. Pediatric oral dosage forms should not be given with milk formulas and should be given at least one hour prior to feeding.

In patients with renal impairment (see **WARNINGS**), total dosage should be decreased by reducing recommended individual doses or by extending time intervals between doses.

In streptococcal infections, a therapeutic dose should be given for at least 10 days.

SUPPLIED Rondomycin (methacycline HCl) 150 mg and 300 mg capsules, syrup containing 75 mg/5 cc methacycline HCl.

Before prescribing, consult package circular or latest PDR information.

Rev. 6-7



WALLACE LABORATORIES
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Is He a Source of Information?

Yes, with certain reservations. The average sales representative has a great fund of information about the drug products he is responsible for. He is usually able to answer most questions fully and intelligently. He can also supply reprints of articles that contain a great deal of information. Here, too, I exercise some caution. I usually accept most of the statements and opinions that I find in the papers and studies which come from the larger teaching facilities. It goes without saying that a physician should also rely on other sources for his information on pharmacology.

Training of Sales Representatives

Ideally, a candidate for the position as a sales representative of a pharmaceutical company should be a graduate pharmacist who has a questioning mind. I don't think this is possible in every case, and so it becomes the responsibility

of the pharmaceutical company to train these individuals comprehensively. It is of very great importance that the detail man's knowledge of the product he represents be constantly reviewed as well as updated. This phase of the sales representative's education should be a major responsibility of the medical department of the pharmaceutical company.

I am certain that most of these companies take special care to give their detail men a great deal of information about the products they produce—information about indications, contraindications, side effects and precautions. Yet, although most of the detail men are well informed, some, unfortunately, are not. It might be helpful if sales representatives were reassessed every few years to determine whether or not they are able to fulfill their important function. Incidentally, I feel the same way about periodic assessments of everyone

in the health care field, whether they be general practitioners, surgeons or salesmen.

Value of Sampling

I personally am in favor of limited sampling. I do not use sampling in order to perform clinical testing of a drug. I feel that drug testing should rightly be left to the pharmacology researcher and to the large teaching institutions where such testing can be done in a controlled environment.

I do not use samples as a "starter dose" for my patients. I do, however, find samples of drugs to be of value in that they permit me to see what the particular medication looks like. I get to see the various forms of the particular medication at first hand, and if it is in a liquid form I take the time to taste it. In that way I am able to give my patients more complete information about the particular medications that I prescribe for them.

capacity they are indeed useful; particularly in the fact that they disseminate broadly based educational material and serve not just as "pushers" of their drugs.

The Other Side of the Coin

Obviously, the pharmaceutical companies are not producing all this material as a labor of love—they are in the business of selling products for profit. In this regard the ambitious and improperly motivated sales representative can exert a negative influence on the practicing physician, both by presenting a one-sided picture of his product, and by encouraging the practitioner to depend too heavily on drugs for his total therapy. In these ways, the salesman has often distorted objective reality and undermined his potential role as an educator.

The Industry Responsibility

Since the detail man must be an information resource as well as a representative of his particular pharmaceutical company, he should be carefully selected and

thoroughly trained. That training, perforce, must be an ongoing one. There must be a continuing battle within and with the pharmaceutical industry for high quality not only in the selection and training of its sales representatives, but also in the development of all of its promotional and educational material.

The industry must be ready to accept constructive as well as corrective criticism from experts in the field and consumer spokesmen, and be willing to accept independent peer review. The better educated and prepared the salesman is, the more medically accurate his materials, the better off the pharmaceutical industry, health professionals and the public—i.e., the patients—will be.

Physician Responsibility

The practicing physician is in constant need of up-dated information on therapeutics, including drugs. He should and does make use of drug information and answers to specific questions supplied by the pharmaceutical representative. However, that informa-

tion must not be his main source of continuing education. The practitioner must keep up with what is current by making use of scientific journals, refresher courses, and information received at scientific meetings.

The practicing physician not only has the right, but has the responsibility to demand that the pharmaceutical company and its representatives supply a high level of valid and useful information. I feel certain that if such a high level is demanded by the physician as well as the public, this demand will be met by an alert and concerned pharmaceutical industry.

From my experience, my impression is that sectors of the pharmaceutical industry are indeed ethical. I challenge the industry as a whole to live up to that word in its finest sense.

*Pharmaceutical
Manufacturers Association
1155 Fifteenth Street, N.W.
Washington, D. C. 20005*



for Continuing Education, Bowman Gray School of Medicine, Winston-Salem 27103

April 7-11

Practical Approaches to Diabetic Care

Program especially suitable for nurses caring for large numbers of diabetic patients. Emphasis on teaching needs of diabetic patients and how to meet them

Fee: \$125

For Information: Judith E. Wray, Administrative Secretary, Continuing Education Program, UNC School of Nursing, Chapel Hill 27514

April 11

North Carolina Diabetes Association Eighth Annual Scientific Session

The program will include a scientific session for physicians and a separate and concurrent session for laymen

Place: Babcock Auditorium

For Information: Emery C. Miller, M.D., Associate Dean for Continuing Education, Bowman Gray School of Medicine, Winston-Salem 27103

April 21-22

Primary Nursing

Participants will explore the use of the primary system and its relationship to other systems, and identify its influence on the nursing process, patient care and staffing

Fee: \$50

For Information: Judith E. Wray, Administrative Secretary, Continuing Education Program, UNC School of Nursing, Chapel Hill 27514

April 23-25

Maternal Health and Family Planning

Designed to assist nurses to conduct classes for parents in prepared childbirth

For Information: Judith E. Wray, Administrative Secretary, Continuing Education Program, UNC School of Nursing, Chapel Hill 27514

May 13-14

Breath of Spring, '75—Respiratory Care Symposium

Place: Babcock Auditorium

Sponsors: Division of Continuing Education, Bowman Gray School of Medicine; Northwestern Lung Association

Fee: \$25

Credit: 12 hours Category I AMA; AAFP applied for

For Information: Emery C. Miller, M.D., Associate Dean for Continuing Education, Bowman Gray School of Medicine, Winston-Salem 27103

Continuing Education via Satellite

The following programs are scheduled to be received from the ATS-6 communications satellite, by the veterans' hospitals at Fayetteville, Oteen and Salisbury on the dates indicated. Sessions are open to all physicians and other interested health professionals.

December 18—1 p.m., "Psychiatry Conference"

December 25—No program, due to holidays

January 1—No program, due to holidays

January 8—1 p.m., "Cardiology Conference"

January 15—1 p.m., "Radiology Conference"

January 22—1 p.m., "TBA Nursing Conference"

January 29—1 p.m., "Pathology, Histology Tissue"

As this schedule has been subject to some change, it might be advisable to check with one of the following before attending:

Fayetteville—Mr. Kenneth Gath (488-2120)

Oteen—Stewart Scott, M.D. or Mary Ellen Lutz, R.N. (298-7911)

Salisbury—Mr. Dante Spagnolo (636-2351)

Programs in Contiguous States

December 16-20

Team Leadership in Community Health Nursing (nurses)

For Information: Mrs. Helen O'Toole, Medical University of South Carolina, Division of Continuing Education, 80 Barre Street, Charleston, S. C. 29401

January 8, 15, 22, 29

Medical Hypnosis

Place: Porter Auditorium (sixth floor), Sanger Hall. Time: 7-9 p.m.

Fee: \$50

For Information: Dr. Charles E. Smith, Department of Psychiatry, Medical College of Virginia, Box 907, MCV Station, Richmond, Virginia 23298

January 20-23

The Alton D. Brashear Postgraduate Course in Head and Neck Anatomy

Sponsors: Department of Anatomy, in cooperation with the Division of Continuing Education, School of Medicine and School of Dentistry.

Program: The primary teaching method of this course is the dissection of the head and neck. Fresh specimens (unpreserved), when available, are used to be as life-like as possible. Individual, surgical approaches and manipulations are welcomed. Lectures and demonstrations will augment the laboratory dissections.

Tuition: \$180; \$95 for students in residency programs. Limited to 32 registrants.

Credit: 40 hours: Academy of General Dentistry; AAFP

For information: Dr. Hugo R. Seibel, Department of Anatomy, Medical College of Virginia, MCV Station, Richmond, Virginia 23298

January 25

Ventilatory Problems Workshop

Place: Holiday Inn, Oak Ridge, Tennessee

For Information: Doris Croley, Oak Ridge Hospital of the United Methodist Church, Oak Ridge, Tennessee 37830

February 16

Cancer of the Breast, a postgraduate course

Place: Hyatt Regency Atlanta Hotel, Atlanta, Georgia

For Information: A. Hamblin Letton, M.D., Secretary-Treasurer, the Southeastern Surgical Congress, 340 Boulevard N.E., Atlanta, Georgia 30312

February 17-20

Southeastern Surgical Congress, 43rd Annual Assembly, for Doctors & Nurses

Place: Hyatt Regency Atlanta Hotel, Atlanta, Georgia

For Information: A. Hamblin Letton, M.D., Secretary-Treasurer, the Southeastern Surgical Congress, 340 Boulevard N.E., Atlanta, Georgia 30312

February 28-March 2

Annual Meeting Virginia Chapter American Academy of Pediatrics

Place: Colonial Williamsburg, Virginia

Fee: \$10

For Information: James H. Stallings, Jr., M.D., Secretary-Treasurer, Virginia Chapter American Academy of Pediatrics, 6503 N. 29th Street, Arlington, Virginia 22213

April 26-30

International Biomaterials Symposium

Sponsors: Clemson University and the National Institute for Dental Research

Fee: \$150

For Information: Professor J. K. Johnson, Continuing Engineering Education, 116 Riggs Hall, Clemson University, Clemson, S. C. 29631

May 12-15

Cardiology for the Internist

Place: Royal Coach Motor Hotel, Atlanta, Georgia

Sponsors: American College of Cardiology; Council on Clinical Cardiology, American Heart Association; Department of Medicine, Emory University School of Medicine, Atlanta, in cooperation with Georgia Heart Association

For Information: Miss Mary Anne McInerney, Director, Department of Continuing Education Programs, American College of Cardiology, 9650 Rockville Pike, Bethesda, Maryland 20014

Rehabilitation of Stroke Patients

A series of workshops on rehabilitation of stroke patients will be conducted as a special project of the South Carolina Heart Association. The overall goal of the project, entitled "Regionalization of Specialized Nursing Home Services," is to upgrade the care of geriatric patients through the latest methodology in stroke patient care. Each workshop will consist of a two-day training session and a one-day follow-up session for review and evaluation. Dates and locations of the workshop sessions are as follows:

January 14-15 & March 20—Rock Hill, S. C.
January 21-22 & March 6—Aiken, S. C.
January 28-29 & March 5—Orangeburg, S. C.
February 11-12 & April 8—Sumter, S. C.
February 18-19 & April 3—Columbia, S. C.
February 25-26 & April 9—Florence, S. C.
March 11-12 & May 1—Myrtle Beach, S. C.
March 18-19 & May 6—Spartanburg, S. C.

For Information: Mrs. Dolores J. Wilkie, P. O. Box 5937, Columbia, S. C. 29250

Sesquicentennial Seminars for Physicians

The programs will be presented by "world renowned medical teachers"

Credit: Continuing education credit for the AMA Physicians Recognition Award

Dates, department presenting the program and speakers are as follows:

January 6-7, Anatomy—Dr. Charles P. Leblond of McGill University, Montreal, Canada
January 16-17, Physical Medicine—Dr. John V. Basmajian of Emory University
January 23-24, Laboratory Medicine—Dr. J. Roger Edson, University of Minnesota, Mayo Graduate of Medicine
February 10-11, Anesthesiology—Dr. Charles Ronald Stephen of Washington University, St. Louis
February 20-21, Biochemistry—Dr. Sidney Udenfriend of the Roche Institute of Molecular Biology
February 27-28, Biometry—Dr. Ling Chun Li, University of Pittsburgh

For Information: Department of Continuing Medical Education, Medical University of South Carolina, 80 Barre Street, Charleston, S. C. 29401

Items submitted for listing should be sent to: WHAT? WHEN? WHERE?, P. O. Box 8248, Durham, N. C. 27704, by the 10th of the month prior to the month in which they are to appear.

AUXILIARY TO THE NORTH CAROLINA MEDICAL SOCIETY

TELL IT AND SELL IT

Communicate! This is what the marriage counselor tells the couple and what the child psychiatrist tells the parent and child. And it is exactly what the AMA Medical Auxiliary is telling its members. The Auxiliary this year is adding a new meaning to the word "communication." As we have indicated, it should encompass the whole world of public relations.

Mrs. T. S. Cheek of Smithfield, the State Auxiliary Chairman for Communications and Public Relations, attended the AMA Auxiliary Southern Regional Workshop held in New Orleans, October 24-25. She brought back a number of definitive points

ers for the improvement of public relations in connection with the North Carolina Medical Auxiliary on the county and the state levels.

First and foremost, it is urged that we have new ideas and that we do not hesitate to discard ideas long since dead. A good test of what is "dead" is seeing how new members respond to a so-called "established idea." If the response is negative, or one of bewilderment, then perhaps the idea should be scrutinized.

We should learn how to use our publications to the fullest to do the job of communicating. The Auxiliary's state and national publications tell a story, and they tell it well. The articles from these publications, full of new ideas and experiences, can be used in every chapter's program. It is suggested that the communications chairmen meet with their respective presidents and vice presidents in planning their programs for the year.

The national office of the Auxiliary can only guess at individual community needs, so rather than catering solely to national needs, it urges that those of the individual community be met primarily.

Small communities usually know when a new prospective member has moved into town, but large medical groups must make a special effort to keep informed of new residents. In small or large communities, prospective new members should be asked to

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attend the meetings, and hopefully they will get involved.

We should encourage all members to make use of their talents. Members of the auxiliaries are volunteers, and interest wanes fast when volunteers are routinely asked to function outside their areas of expertise.

The Auxiliary recommends rapport with the Medical Society. We should report to the Medical Society on the Auxiliary's activities, and we should make projects community oriented in order to get the Society's backing.

Establish a two-way channel — better known as "feedback." The Auxiliary, both state and national, wants to hear about the results of projects. *Communicate in any and every way that it can be done.* A good slogan to remember is this: "You can't sell it if you don't tell it!"

The NCMA Mid-Winter Conference, with the theme "Leadership and Communication," to be held at the NCMS Headquarters in Raleigh, February 1, will afford the opportunity to "tell it and sell it." County auxiliaries are urged to put this date on their calendars and to make certain that representatives attend.

News Notes from the—

BOWMAN GRAY SCHOOL OF MEDICINE WAKE FOREST UNIVERSITY

Dr. William M. McKinney, associate professor of neurology, is the new president of the American Institute of Ultrasound in Medicine (AIUM). He was installed as president at the organization's October meeting in Seattle, Wash. Dr. Ralph Barnes, research assistant professor of neurology, has begun a three-year term as a member of the AIUM executive board. James W. Willard, research associate in urology, was awarded second prize by the American Society of Ultrasound Technical Specialists (which met along with the AIUM) for his paper entitled "Ultrasonography of the Prostate and Related Structures."

The 1975 meetings of AIUM and ASUTS were held in Winston-Salem Oct. 4-9.

* * *

Dr. Clark E. Vincent, professor of sociology and director of the Behavioral Sciences Center, has received a special award from the California Association of Marriage and Family Counselors for his literary contributions in the field of counseling.

The award was presented during the 33rd annual meeting of the American Association of Marriage and Family Counselors.

Dr. Vincent just completed his term as president

of the AAMFC, and is continuing to serve on the board of directors. He is the first person ever to have served as head of all four major marriage and family organizations in the nation.

* * *

Bowman Gray has signed a contract with the University of North Carolina School of Medicine, accepting responsibility for developing an Area Health Education Center program in a 16-county region of northwest North Carolina.

Dr. Richard Janeway, Bowman Gray dean, and Dr. Christopher Fordham, dean of the UNC medical school, signed the contract, which sets into motion a planning phase, lasting until July 1, 1975.

Under the AHEC, Bowman Gray is developing a Department of Family medicine and will start 75 new residencies in primary care fields over a three-year period. As part of the new department's creation, Bowman Gray has recently signed an affiliation agreement with Forsyth Memorial Hospital and the Family Health Center of Reynolds Memorial Hospital.

The AHEC program will also involve an outreach effort, touching as many of the 30 community hospitals in the 16-county region as wish to participate. Bowman Gray will be offering continuing education programs for physicians and those in allied health fields, as well as helping in the development of community health centers.

The new AHEC program has the cooperation of the UNC-G School of Nursing and the schools of dentistry, pharmacy and public health of the University of North Carolina.

* * *

Dr. Ernest H. Stines of Canton has been elected president of the Alumni Association of the Bowman Gray School of Medicine. Dr. Giles L. Cloninger of Hamlet is the association's new president-elect.

Drs. George H. Armstrong of Mount Gilead, Len D. Hagaman of Boone, Dewitt Trivette of Hickory, Erich W. Schwartz of Waco, Tex., and Betsy A. Parsley of Winston-Salem have been elected to the association's alumni council.

Dr. Jean Bailly Brooks of Greensboro, retiring president of the alumni association, was presented an award for distinguished service to the association during the association's annual dinner recently.

* * *

Dr. Timothy Pennell, associate professor of surgery, recently began a three and a half week assignment in Africa and India under the auspices of the Foreign Missions Board of the Southern Baptist Convention and the medical school.

His responsibilities included teaching at universities and medical schools, observing health care programs in the mission hospitals and evaluation of the hospitals.

* * *

Dr. James F. Martin, professor of radiology, has

en elected secretary of the American Roentgen
ay Society.

* * *

Three Bowman Gray and Baptist Hospital physi-
cians recently returned from Honduras, where they
provided medical care to victims of Hurricane Fifi.
Dr. John Denham, instructor in community medi-
cine, joined Dr. Richard Sterba, a resident in pedi-
atrics, and Dr. Michael Roberts, a resident in surgery,
making the two-week trip under the auspices of
the Foreign Missions Board of the Southern Baptist
convention.

The three physicians spent their time in rural areas
around San Pedro Sula, a particularly hard-hit coastal
town. They provided basic medical care in field hos-
pital-type units.

* * *

Dr. B. Lionel Truscott, professor of neurology,
has been named advisory consultant to the Office
of Biometry, Collaborative and Field Research Pro-
gram of the National Institute of Neurological
Diseases and Stroke.

* * *

Dr. Walter A. Ward, assistant professor of
otolaryngology, was elected secretary/treasurer of
the American Society of Ophthalmologic and Oto-
laryngologic Allergy at an October meeting of the so-
ciety in Dallas, Tex.

News Notes from the—

UNIVERSITY OF NORTH CAROLINA DIVISION OF HEALTH AFFAIRS

Dr. Lewis Thomas, author of "Lives of a Cell,"
presented the McNair Lecture at UNC-Chapel Hill
on October 31 in Memorial Hall. Dr. Thomas, presi-
dent of the Memorial Sloan-Kettering Cancer Center
in New York City discussed "Biological Aspects of
Cancer."

* * *

After an extensive 18-month study into the feasi-
bility of developing a Health Maintenance Organiza-
tion (HMO) in Chapel Hill, the Steering Committee
for the project has decided that further planning ef-
forts cannot proceed until questions concerning the
financial support for start-up costs and the avail-
ability of local leadership for such a venture are
answered. However, because recent events, such as
the enactment of federal legislation aiding HMO de-
velopment, might lead to the resolution of these local
difficulties, the Steering Committee intends to re-
examine the Chapel Hill HMO effort within the year.

Dr. Cecil G. Sheps, vice chancellor for health
sciences at UNC-Chapel Hill, is chairman of the
steering committee of the Chapel Hill HMO Plan-
ning Project. Funded by a \$125,000 grant from
NIH, the project was organized in January 1972

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to determine the feasibility of using existing health care resources here for development of an HMO.

* * *

Patients who suffer serious injury, or trauma, and those who undergo major operations often are saddled with lung complications which might result in respiratory failure, causing their lungs to stiffen and making them work harder to breathe.

Dr. Enid Kafer, associate professor of anesthesiology at the UNC School of Medicine, is studying how the respiratory system adjusts to increased workloads. Working under a \$65,000, three-year grant from the National Heart and Lung Institute, she hopes to discover the exact factors involved in respiratory failure and to define better indices for deciding when a patient is able to breathe on his own.

* * *

New faculty members include the following:

Robert E. Cross has been appointed assistant professor in the Departments of Medicine, Biochemistry and Nutrition, and Pathology, and associate director of the Clinical Chemistry Laboratory. He has been a postdoctoral fellow at the University since 1972. His B.S. and M.S. are from the University of Toledo and his Ph.D. is from the University of Florida.

Laurence Ray McCarthy has been appointed assistant professor in the Departments of Bacteriology and Immunology, and Pathology. He has been associate director of the Diagnostic Microbiology Laboratory at the Memorial Sloan-Kettering Cancer Center in New York since 1972. A graduate of St. Anselm's College, he earned his Ph.D. at the University of New Hampshire.

Gerhard W. D. Meissner has been appointed assistant professor in the Departments of Biochemistry and Nutrition, and Physiology. A research assistant professor at Vanderbilt University since 1972, he received the B.S. and M.S. degrees from the Free University of Berlin and the Ph.D. from the Technical University of Berlin.

Lee O. Stang has been appointed assistant professor in the Division of Physical Therapy. She has been director of Physical Therapy Services with the

South Carolina Department of Home Health and Environmental Control since 1972. A graduate of the University of Massachusetts, she earned her Certificate in Physical Therapy at Columbia University College of Physicians and Surgeons and her M.P.H. from UNC-Chapel Hill.

* * *

Noel A. Mazade, assistant professor, Department of Psychiatry, is on a one-year leave to serve as project director of the Pilot Model Area Program with the North Carolina Division of Mental Health Services until July 31, 1975.

* * *

Glenn J. Martin, chief of the Program Experimentation Branch in the Social Security Administration's Bureau of Health Insurance, has been named visiting fellow in the Department of Health Administration (HADM) in the UNC School of Public Health at Chapel Hill.

The Faculty Field Exchange Program developed last year is designed to encourage HADM faculty to gain field experience in the operation and management of health and human service programs and to encourage high-level practicing professionals to contribute to research and teaching.

During his stay in Chapel Hill, Martin will explore payment systems, new coverage provisions with cost containment potential, innovative systems of payment for physician's extender services and the determination of problem areas in extended care benefit provisions. He also will be available as a consultant and advisor to interested students, faculty and health agencies.

News Notes from the—

DUKE UNIVERSITY MEDICAL CENTER

Four medical center faculty members have been promoted to full professor. Ten others were promoted to associate professor, and six were named assistant professors.

Promoted to professorships are Dr. Walter I. Floyd, medicine; Dr. Irwin S. Johnsruide, radiology; Dr. Robert E. Whalen, medicine; and Dr. Robert Wayne Wheat, microbiology.

The ten faculty members awarded associate professorships include Dr. Darell D. Bigner, pathology; Dr. Matthew Cartmill, anatomy and anthropology; Dr. John H. Grimes, urology; Dr. William L. Hallander, anatomy and anthropology; Dr. Charles Johnson, medicine; Dr. Jack L. Nichols, microbiology; Dr. Lois A. Pounds, pediatrics; Dr. Arvin L. Robinson, radiology; Dr. Ralph E. Smith, virology; and Dr. Thomas C. Vanaman, microbiology.

The six new assistant professors are Elaine Ecker, physical therapy; Dr. James Clifford Green, psychiatry; Dr. Jarlath Mackenna, obstetrics and gynecology.

OCEANFRONT PENTHOUSE CONDOMINIUM

For Sale—2 bedroom, 16th Floor Penthouse Condominium in Arcadian II, adjacent to the luxurious new Myrtle Beach Hilton and Dunes Golf Course, with full membership privileges in the nearby Rees Jones designed Arcadian Shores Golf Course. 9%, 25 yr. financing available—Call or write

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logy, and Linda W. Craig, Jane S. Kaufman and Nancy F. Woods, all from the School of Nursing.

* * *

Dr. William G. Anlyan is the new national president of the Association for Academic Health Centers (AAHC).

Anlyan, vice president for health affairs, was installed as the organization's fourth president at its annual meeting in West Palm Beach, Fla.

The AAHC membership is made up of persons at the vice president or chancellor level who have senior administrative responsibilities for academic health centers.

* * *

Dr. John L. Weinerth, assistant professor of urologic surgery, has been named associate director of graduate medical education.

Announcement of the appointment came from Dr. Gerald W. Busse, director of medical and allied health education, and J. P. Gibbons, Professor of Psychiatry.

Weinerth succeeds Dr. M. S. Mahaley, Jr., associate professor of neurosurgery, who has given up the position to devote more time to his clinical practice and research interests. Mahaley has held the post since June of 1972.

Weinerth's responsibilities will include coordinating all educational activities related to residency training and managing the hospital's house staff office. In addition, he will supervise the matching program through which graduating medical students are placed in internships and residencies across the country and serve as a liaison between Duke Hospital and the School of Medicine.

A 1963 graduate of Bucknell University in Lewisburg, Pa., Weinerth received his medical education at Harvard Medical School. Upon graduation from Harvard in 1967, he began a surgical internship at Duke and completed his urologic surgery residency requirements, also at Duke, in 1973.

From September 1969 to September 1970, he headed the Tissue Bank in the Laboratory Services Department at the Naval Hospital in San Diego, and since August of 1972, he has been chief of the Renal Perfusion Unit here in the Department of Surgery's Transplantation Service.

* * *

John D. Shytte, a former controller of the Veterans Administration in Washington, has been named as assistant vice president for health affairs.

He will be responsible for medical center administration and will report to Dr. William G. Anlyan, vice president for health affairs.

Shytte was controller of the Veterans Administration from 1963 until 1972. From 1972 until his appointment at Duke he was director of the Veterans Administration Hospital in Richmond.

A native of Shelby, Shytte, 56, was a cost accountant at Dover Mills in Shelby prior to World War II. During the war he served as a captain with

the 14th Air Force in China, earning a Distinguished Flying Cross with three Oak Leaf Clusters.

Following the war he joined the Veterans Administration, leaving for two years to serve as a senior cost analyst for U. S. Steel in Pittsburgh.

Shytte rejoined the VA in 1949, serving consecutively in the Budget Service, Department of Veterans Benefits and the Department of Medicine and Surgery. In 1961 he was named Budget Officer of the VA, holding that position until being named controller.

Shytte holds a B.S. degree in business administration and M.S. degree in management from George Washington University.

* * *

More than 40 Japanese and American investigators studied the cellular make-up and natural development of the heart muscle in Tokyo in mid-October, thanks largely to the foresight and interest of a Duke physiology professor.

The bilaterally-sponsored seminar, "Developmental Aspects of Cardiac Cellular Physiology," was planned and established by Dr. Melvyn Lieberman, in cooperation with Dr. Toyomi Sano, a professor at Tokyo's Institute for Cardiovascular Diseases.

AMERICAN ACADEMY OF FAMILY PHYSICIANS

Dr. Carl B. Hall of Charleston, West Virginia, was recently named president-elect of the American Academy of Family Physicians at the medical group's Congress of Delegates.

Among other new officers elected by the Congress was Dr. George Wolff of Greensboro, elected to serve a three-year term on the Board of Directors.

AMERICAN COLLEGE OF EMERGENCY PHYSICIANS

North Carolina Chapter

The North Carolina Chapter of the American College of Emergency Physicians has elected the following officers: president, Dr. George Podgorny of Winston-Salem; vice president, Dr. William Barry of Fayetteville; secretary-treasurer, Dr. David S. Nelson of Winston-Salem; councillor, Dr. George Podgorny of Winston-Salem; alternate, Dr. Thomas Berner of Asheville; 2nd alternate, Dr. R. Tempest Lowry of Raleigh.

The following were elected to the Board of Directors: Dr. William Barry of Fayetteville; Dr. Thomas Berner of Asheville; Dr. Hugh Fitzpatrick of High Point; Dr. Frederick W. Glass of Winston-Salem; Dr. Robert S. Jacques of Pittsboro and Pinehurst; Dr. R. Tempest Lowry of Raleigh; Dr. Morton Meltzer of Durham; Dr. Wayne Stockdale of Goldsboro and Smithfield.

NORTH CAROLINA MEDICAL PEER REVIEW FOUNDATION, INC.

The North Carolina Medical Peer Review Foundation, Inc. (NCMPRF), was formed in February 1973 at the direction of the Executive Council of the North Carolina Medical Society, and is dedicated to developing and promoting methods of peer review applicable to all aspects of medical care in the state. Membership in the Foundation is open to any physician licensed to practice in North Carolina, and nearly one-third of all North Carolina's physicians are already members.

NCMPRF, Inc., was formally established in February 1974. M. Frank Sohmer, M.D., Winston-Salem, was elected president and is Acting Medical Director as well, and Dan Mainer, formerly Assistant Executive Director of the North Carolina Medical Society, is Executive Director of the Foundation. The executive offices of the Foundation are located in the Medical Society Building at 222 North Person Street in Raleigh. The telephone number is 919-828-7306.

As part of its continuing obligation to both practitioners and providers of medical care in North Carolina, the Medical Peer Review Foundation is actively developing various kinds of review programs to help ensure that the responsibility for the review of medical services remains with practicing physicians, not with governmental agencies.

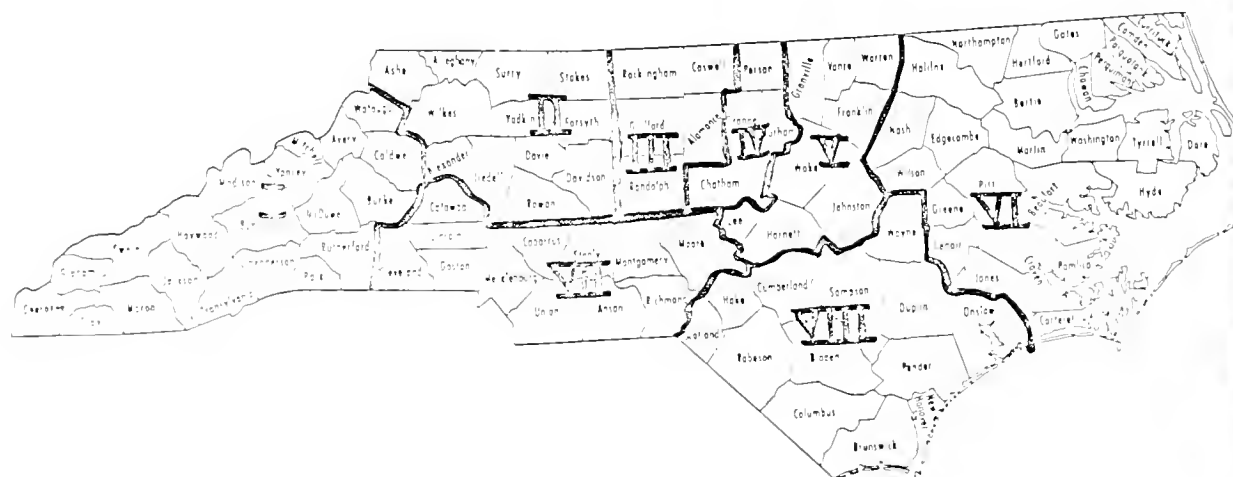
The first program undertaken by the Foundation was educational and was funded by a grant from the North Carolina Regional Medical Program; it was an attempt to familiarize North Carolina physicians with the provisions of the PSRO Law. Physician members of the Foundation's Board of Directors presented a series of seminars throughout the state. The

well attended seminars seemed to answer many physician's questions about PSRO. Under this grant the Foundation has also formed a committee of physicians whose responsibility it is to make formal recommendations concerning criteria for the assessment of the quality of medical care in North Carolina. Its work is expected to take some time, and the committee plans to evaluate pertinent information from the medical staffs of many of the hospitals in the state before making its final recommendation.

On March 28, 1974, the Foundation entered into a contract with the State Department of Human Resources to provide periodic medical review services for Medicaid patients in skilled nursing facilities, psychiatric and tuberculosis hospitals, as required by 45 Code of Federal Regulations 250.23. Under this Program, four Foundation Review Teams, with each team composed of a review physician, nurse, and medical social worker, will evaluate the quality of patient care and appropriateness of the level of care. Each eligible patient will be reviewed two or three times a year.

On July 1, 1974, the Foundation was designated as a statewide PSRO Support Center, by contract with the United States Department of Health, Education, and Welfare (HEW). There are eight designated PSRO areas in the state. In this role, the Foundation proposes to undertake further educational programs concerning the PSRO Law for physicians and other health professionals, and to identify organizations to perform Professional Standard Review in those areas where no appropriate organization has yet emerged. As PSROs are identified in each of these areas, the Foundation is providing professional and technical assistance to these

PSRO DESIGNATIONS FROM
MARCH 18, 1974 FEDERAL REGISTER



NORTH CAROLINA

organizations, as they request it, so that each progresses from the planning phase to conditional operational status.

Areas—(8)	MDs	DOs	Hospitals	Hospital Beds
Area I	518	5	27	2,421
Area II	665	5	19	2,745
Area III	454	2	9	1,698
Area IV	1,012	0	8	1,823
Area V	375	2	12	1,586
Area VI	459	3	23	2,115
Area VII	867	8	22	4,102
Area VIII	432	3	14	2,235
TOTAL	4,791	28	134	18,725

At present, NCMPRF, Inc., is assisting with organizational activities in eight of the eight designated SRO Areas in North Carolina. Area I had an organizational meeting in late October, inviting chiefs of hospitals staffs of all hospitals in the area, as well as presidents of county medical societies, for their initial discussion of the approach to organizing

a non-profit corporation. Area II has received a planning grant from HEW for a six-month period, which began July 1, 1974; it is making preparations for applying to HEW as a Conditional PSRO, known as the Piedmont Medical Foundation, with headquarters in Winston-Salem. Area III has had several organizational meetings and has formed a corporation known as the North Central Peer Review Foundation, headquartered in Greensboro, and NCMPRF, Inc., is assisting this organization in applying for a planning grant at the time of the next contract award period. Area VI has had two organizational meetings and formed the Northeastern North Central Medical Peer Review Foundation, headquartered in New Bern, North Carolina. NCMPRF, Inc., is assisting this corporation in making preparations to apply for a planning grant. Area VII had one organizational meeting, and another was scheduled for late October to formally organize a non-profit corporation for seeking a planning grant. Area VIII has completed an initial organizational meeting and scheduled another for their corporate organization in late October.



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FELLOWSHIP HALL WILL ARRANGE CONNECTION WITH COMMERCIAL TRANSPORTATION.

Month in Washington

Though Senator Russell Long (D-La.) may make an attempt to win Senate approval of his social security-catastrophic national health insurance proposal when the Congress returns in late November, most Capitol Hill observers believe such legislation's chances of passage are less than that of Henry Mencken's snowball in hell.

* * *

The American Medical Association is now in the process of reviewing and updating its position on national health insurance, Malcolm C. Todd, M.D., has told Washington groups.

"Our objective is to make the AMA's national health insurance proposal more flexible, while at the same time maintaining certain basic precepts," Dr. Todd said.

"If necessary, we may compromise on the method of financing we adopt. But we are not willing to fund national health insurance through an increase in Social Security taxes; nor are we willing to see the program administered by the Social Security Administration.

"We want a financing mechanism for comprehensive health insurance that will do the most at the least cost. This could involve: increase employer-employee contributions for private health insurance; the use of general tax revenues; or, an individual tax credit to be applied toward full health care protection. This latter method was, of course, the method employed in Mediredit.

"The important point is that we cannot countenance greater fiscal and bureaucratic authority for the Social Security Administration or an increase in the Social Security tax.

"Any payroll tax, whether collected under Social Security or not, constitutes the most insidious form of taxation that can be invoked by government. It is a totally regressive tax that weighs heavily on low and middle income workers and lightly on the affluent.

"Finally, the measure that emerges will provide comprehensive health care benefits as well as protection against the catastrophic costs of prolonged illness for every American," Dr. Todd said.

* * *

A batch of major health bills is hanging afire for the "lame duck" session of Congress starting Nov. 18. Comprehensive health planning bills have cleared the Senate but not the House. Though no public utility-

type regulation is in prospect, other measures strengthening government planning authority abound.

Health manpower legislation with provisions for federal service in shortage areas is through Senate. House action is expected shortly after Congress returns. There is a possibility that one or both may be stalled in conference as the Administration now wishes simple extension of present programs.

A health revenue sharing bill will be taken up again by a House-Senate conference. This measure extends state health block grants, community mental health centers, family planning, migrant health and neighborhood health center programs. It should secure Congressional enactment this year.

The Health Education and Welfare appropriation bill still has to be completed.

No chance is seen for passage of the Omnibus Drug amendments bill that would provide Medicare outpatient drug benefits, a Federal Formulary, and the Administration's low-cost drug plan for Medicare-Medicaid patients.

* * *

The Health Education and Welfare Department has issued final regulations on benefits and structure of Health Maintenance Organizations, giving the green light to federal grants launching the program.

The regulations set forth the rules, restrictions and benefits that must be followed in order for organizations to qualify as HMOs and receive federal aid. The \$325 million HMO program was approved by Congress in 1973.

Grants can now be made among the 125 groups that have applied for funds to conduct feasibility studies, planning and development.

The HMO Act authorizes federal support for five years "to demonstrate more broadly the concept of organizations delivering comprehensive health care services on a prepaid basis." Last year Congress appropriated \$61 million. The Administration sought \$60 million this year, but the Senate approved only \$18 million because of a delay due to the development of the complicated regulations.

The regulations specify basic services to be provided in return for fixed payments made on a periodic basis without regard to the frequency, extent, or kind of services provided, with the payments set on a community rating system. These may be supplied

nted by what the regulations call "nominal co-
yments" limited under a variety of formulas.

Before the HMO program can be launched, still
ore regulations will have to be completed. The
st important is the statutory requirement that
employers with more than 25 workers offer the em-
ployees the option of joining a qualified HMO if
e is available. These proposed regulations are
ted to be issued soon, but final ones are some
onths off.

Though suggestions were made to exempt HMOs
m Professional Standards Review Organization
SRO) authority, HEW rejected them, declaring
t there is a need "to assure that suitable proce-
res are applied to HMO services to assure they
hform to appropriate professional standards for the
vision of health care applicable to other pro-
lers."

Basic HMO benefits must include: physician ser-
es (including consultant and referral services by a
ysician); outpatient services and inpatient hospital
vices; medically necessary outpatient and inpatient
ergency health services; short-term (not to exceed
visits), outpatient evaluative and crisis inter-
tion mental health services; medical treatment and
erral services (including referral services to ap-
ropriate ancillary services) for the abuse of or ad-
dition to alcohol and drugs; diagnostic laboratory
1 diagnostic and therapeutic radiologic services;
me health services; and preventive health services
cluding voluntary family planning services, ser-
es for infertility, preventive dental care for chil-
en, and children's eye examinations conducted to
termine the need for vision correction).

* * *

The General Accounting Office (GAO) has
arged that per capita payments for Medicaid pa-
nts enrolled in prepaid health plans in California
ceeded average fee-for-service costs on one of two
ot projects studied.

In a report to the Senate Finance Committee, the
AO also said that Medicaid enrollees in the prepaid
ins "have made many complaints about the quality
medical care," especially the lack of a personal
nily physician.

About three percent of the Medicaid patients in
cal 1972 dropped out of the plans each month
th the exception of the Sacramento Foundation
community Health plan where the rate was only .3
cent, a difference attributed by GAO probably
the fact that the Foundation allows most en-
lees to remain with their family physicians.

However, GAO, Congress' watchdog on federal
penditures, said the Foundation was paid \$406,000
ore for Medicaid patients than per capita fee-for-
vice estimates for the group.

The agency recommended that the HEW Depart-
ent establish surveillance mechanisms to insure that
sts of HMO do not exceed the costs of fee-for-
vice.

A controversial draft report that showed two Blue
Cross Medicare intermediaries with substantially
lower administrative costs than those of the Social
Security Administration's Bureau of Health Insur-
ance (BHI) has been pulled back by the General Ac-
counting Office and is being redone, according to the
Washington Report on Medicine and Health. BHI
has objected to the comparison as invalid and GAO
has protested Blue Cross use of the draft which had
been put out on a confidential basis.

* * *

Physicians, patients and fellow workers have re-
acted favorably to the Physician Assistants (PA)
employed in a pilot experiment by Kaiser Founda-
tion Health Plan, according to a report on the pro-
gram.

At present, seven PAs are on duty at Kaiser. The
first was hired in 1970, a graduate of the Duke Uni-
versity PA program and a former military corpsman.

There was concern by some physicians and ad-
ministrators, but "the greatest resistance came from
the nursing department," writes Kaiser official Paul
Lairson, M.D., in *Inquiry*, the Blue Cross Associa-
tion magazine.

As the nurses began to work with the PA and
learned from experience that there was more of an
"equal relationship" with him than with the physi-
cians, they became a "traditional team," Dr. Lairson
declared. Furthermore, "all but one of the physicians
who worked in the clinic with the PA came to favor
expanding the program," he said.

The PA saw approximately 20 patients each day
at the Vancouver, Washington, clinic. He was given
three physical examination appointments, and the
rest of his time was rapidly filled with the "treat-
ment of relatively minor medical and surgical prob-
lems, whether by appointment or on a 'drop-in'
basis." More severe or chronic problems were trans-
ferred to the internist or other specialist.

* * *

The tax reform bill before the House Ways and
Means Committee has a provision to discourage pro-
fessional conventions by American organizations in
foreign countries.

Exempted would be Canada, Mexico, Bermuda
and the Caribbean. The taxpayer must show that it
was "more reasonable for the meeting to be held
outside North America," to secure a business expense
deduction. Not affected would be meetings an-
nounced before September 11, 1974.

The amendment is aimed at national conventions
being held in faraway tourist attractions where at-
tendees deduct their travel and other expenses as
business-connected.

* * *

The Department of Health, Education and Wel-
fare has announced that, commencing with the first
of the new year, the Medicare hospital deductible
will jump to \$92. The present deductible is \$84.

HEW said that the \$92 deductible is equivalent

to the average cost of one day of hospitalization. The increased payment was brought about by rising hospital costs, according to HEW.

The Medicare law requires an annual review of hospital costs under Medicare and an adjustment of the portion of the bill for which a Medicare beneficiary is responsible, if the costs have risen substantially.

When the hospital deductible amount changes, the law requires comparable changes in the dollar amounts that a Medicare beneficiary pays toward a hospital stay of more than 60 days, or an Extended Care Facility (ECF) stay of more than 20 days.

When a Medicare beneficiary has a hospital stay of more than 60 days, he will pay \$23 a day for the 61st through the 90th day, up from the present \$21 per day. If he has a posthospital stay of over 20 days in an ECF, he will pay \$11.50 per day toward the cost of the 21st day through the 100th day, up from the present \$10.50 per day.

If a beneficiary uses his "lifetime reserve" day, the extra 60 hospital days a beneficiary can use when he needs more than 90 days of hospital care in the same benefit period will cost him \$46 for each reserve day used, instead of the present \$40 per day.

Book Reviews

Emergency Medical Services: Behavioral and Planning Perspectives. John H. Noble, Jr., Henry Wechsler, Margaret E. LaMontagne, and Mary Anne Noble (eds). 595 pages. Price, \$24.95. New York: Behavioral Publications, 1973.

Over the years, all hospitals have had great difficulty in coping with the onslaught of patients in their emergency departments. "Without design, emergency departments have taken on, in addition to their traditional role, the buffering function of regulating the imbalance of the overall health care system."

The preceding quotation (from the foreword by Dr. James D. Mills, president of the American College of Emergency Physicians) succinctly states the basic theme of this compendium of articles on Emergency Medical Services. The editors selected the articles from the literature of the past 15 years. They grouped them into four sections and introduced each with a brief review of each article.

The first section is on systems of emergency medical care and comprises five articles: the first article analyzes emergency medical care problems as part of the general crisis of health care and the inaccessibility of health care to many Americans; the second is the only known nationally representative study of hospital emergency facilities (written in the late 1950s); the third analyzes the highly successful network of emergency stations in San Francisco; the last two, examples of systems analysis, utilize analytic models of community emergency care.

The articles in the second section relate to patterns of utilization. These articles analyze either (1) the types of patients who use the emergency room for emergency or nonurgent care, and relate income,

living area and relationships with private physicians or hospitals to such use, or (2) the interrelationships between physicians, patients and outpatient medical care.

Section three, which comprises seven articles on transportation and communication, concerns the means of conveying (recovering) patients to the emergency room and the costs and efficiency of various "recovery" systems and disaster plans. This section is the most cohesive of the four and it most clearly concerns true emergency care.

Section four contains a potpourri of articles on standards and policies. It covers (1) the failure of many hospitals to meet the emergency needs of the public, even when adequate guidelines have been given, (2) the problems of staffing emergency rooms with "moonlighting" interns and residents, (3) the professional and legal responsibilities of nurses and physicians in emergency rooms and the related responsibilities of hospital trustees and administrators, (4) the emergency room's responsibilities to the press, particularly regarding legal aspects versus the public's "right to know," and (5) a planning perspective for communities that must integrate the many components of emergency health care.

Because of the incredibly rapid expansion of interest and activity in emergency care programs, the book is already outdated. It makes little reference, for example, to the many recently established residency training programs for full-time emergency physicians. It offers very few solutions to the many problems that relate to emergency versus primary care.

Despite the foregoing deficiencies, however, the compilation of articles, accompanied by pertinent

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editorial comments, is an excellent source book of information on emergency medical services in this country.

JAMES T. MCRAE, M.D.

Essays on Longevity. By Samuel Kahn, M.D. 198 pages. \$10.00. New York: Philosophical Library, 1974.

Essays on Longevity is essentially a spiel, elucidating the obvious or oversimplifying the complicated. It reads as if the author believed he has discovered eternal life.

For example, Dr. Kahn says:

Posture is very important. The man or woman who carries the head high, the chin up, shoulders straight and chest out is on the right road to a long life. The resistance of the lungs is lowered when the posture is bad, and you may invite diseases in the chest, pelvic or abdominal muscles. Long life and poor posture are not good friends. The lazy carriage bespeaks a lazy body and a lazy body bespeaks a lazy mind. Either or both may be fatal to longevity. When you walk, sit, play or work, always remember good posture—it will prolong your life and add to your personality.

He suggests we, "Eat the following fish: cod mackerel, haddock, halibut, blue fish, bass and flounder" to help prevent cardiovascular renal disease.

After reading such instructions for 200 pages, cannot help thinking of my uncle who died at 80 after smoking three packages of cigarettes a day for 70 years. Each in his own way, Dr. Kahn and Uncle Bill seem foolish.

WILLIAM D. POE, M.D.

The Doctors' Guide to Better Tennis and Health. Claude A. Frazier, M.D. (ed). 126 pages. Price, \$5.95. New York, N. Y.: Funk & Wagnalls Publishing Co., 1974.

This small book, edited by tennis enthusiast Dr. Claude A. Frazier of Asheville, North Carolina, is both readable and concise. The chapters are written by experts in their chosen fields. Although there is little in the way of new information for the physician, the book should be a helpful reference source for the tennis-playing family.

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In Memoriam

James Breckinridge Loundsbury, M.D.

James Loundsbury, M.D., died June 20, 1974, at the age of 65 years. He was born in Wilmette, Illinois, and completed primary schooling there. He attended the Hotchkiss School, Lakeville, Connecticut, and Yale undergraduate school. He graduated from Yale Medical School in 1935 with the M.D. degree. Dr. Loundsbury then served a rotating internship at University Hospital, Ann Arbor, Michigan, for one year, after which he served two years at the University of Michigan as a lecturer in Public Health and Hygiene. He spent one year as surgical resident at the University of Michigan and served as resident in Obstetric/Gynecology at the University Hospitals in Cleveland, Ohio. He served his final year at Voman's Hospital, Detroit, Michigan, finishing his training in 1941.

Dr. Loundsbury married Beatrice Thomen and came to Wilmington in 1941 where he was on the staff of James Walker Memorial Hospital prior to serving in the Navy Medical Corps during World War II. At the end of his service he returned to Wilmington where he stayed until his death. In addition to being a member of the attending staff of the New Hanover Memorial Hospital, he was on the courtesy staff of Cape Fear Memorial Hospital and the consulting staff of Doshier Memorial Hospital at Southport, North Carolina.

Dr. Loundsbury served the community for many years as chief obstetrician of the Maternity Clinic of the New Hanover County Health Department. He was a member of the American Medical Association, Medical Society of New Hanover County, American College of Surgeons, American Gynecological Society, North Carolina Obstetrical and Gynecological Society, American College of Obstetrics and Gynecology, and was a Diplomat of the American Board of Obstetrics and Gynecology.

Besides his many medical accomplishments, Dr. Loundsbury enjoyed several hobbies, but he primarily loved to play golf. He became interested in boating after his retirement in 1969, and served as a lieutenant in the local chapter of the Power Squadron and was treasurer for the five years preceding his death.

Jim Loundsbury was a true friend and accomplished physician. He will be sorely missed and fondly remembered.

Surviving are his widow, two daughters, Barbara and Jean, four grandchildren, and a brother, Richard C. Loundsbury of Sherman, Connecticut.

NEW HANOVER-PENDER-BRUNSWICK COUNTY
MEDICAL SOCIETY

Luther W. Kelly, Sr., M.D.

Dr. Luther W. Kelly, Sr., died on August 23, 1974. He received his Doctor of Medicine Degree from the University of Virginia and served his internship and medical residency at Boston City Hospital. Dr. Kelly came to Charlotte in 1928.

Dr. Kelly was born on April 14, 1896, in Philadelphia and moved to Williamsburg, Virginia, at the age of 12. He joined the Nalle Clinic in 1929 where he continued his medical practice until 1971, at his retirement. He was chairman of the Department of Medicine at Charlotte Memorial Hospital when it first opened its doors. He was president of the Mecklenburg County Medical Society in 1947 and was an organizing member of the Charlotte and North Carolina Societies of Internal Medicine.

Dr. Kelly was a colleague and friend who exemplified the fine things we mean when we say that he was a gentleman and physician.

MECKLENBURG COUNTY MEDICAL SOCIETY

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NORTH CAROLINA MEDICAL SOCIETY

TRANSACTIONS

One Hundred Twentieth Annual Session
held at
Pinehurst, North Carolina
May 18-22, 1974

Briefed and Abridged by
William N. Hilliard, Executive Director
North Carolina Medical Society
222 North Person Street, Raleigh, North Carolina 27611



NORTH CAROLINA MEDICAL SOCIETY

TRANSACTIONS

One Hundred Twentieth Annual Session
held at
Pinehurst, North Carolina

May 18-22, 1974

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OFFICERS—1974-1975

<i>President</i>	Frank R. Reynolds, M.D., 1613 Dock St., Wilmington 28401
<i>President-Elect</i>	James E. Davis, M.D., 1200 Broad St., Durham 27705
<i>First Vice-President</i>	Jack Hughes, M.D., 923 Broad Street, Durham 27705
<i>Second Vice-President</i>	M. Frank Sohmer, Jr., M.D., Professional Bldg., Winston-Salem 27103
<i>Secretary</i>	E. Harvey Estes, Jr., M.D., Duke Univ. Med. Ctr., Durham 27710 (1976)
<i>Speaker</i>	Chalmers R. Carr, M.D., 1822 Brunswick Avenue, Charlotte 28207
<i>Vice-Speaker</i>	Henry J. Carr, Jr., M.D., 603 Beamon St., Clinton 28328
<i>Past-President</i>	George G. Gilbert, M.D., 1 Doctors Park, Asheville 28801
<i>Executive Director</i>	William N. Hilliard, 222 N. Person St., Raleigh 27611

COUNCILORS AND VICE-COUNCILORS

<i>First District:</i>	Edward G. Bond, M.D., Chowan Med. Ctr., Edenton 27932 (1977)
<i>Vice-Councilor:</i>	Joseph A. Gill, M.D., 1202 Carolina Ave., Elizabeth City 27909 (1977)
<i>Second District:</i>	J. Benjamin Warren, M.D., Box 1465, New Bern 28560 (1976)
<i>Vice-Councilor:</i>	Charles P. Nicholson, Jr., M.D., 3108 Arendell St., Morehead City 28557 (1976)
<i>Third District:</i>	E. Thomas Marshburn, Jr., M.D., 1515 Doctors Circle, Wilmington 28401 (1976)
<i>Vice-Councilor:</i>	Edward L. Boyette, M.D., Chinquapin 28521 (1976)
<i>Fourth District:</i>	Harry H. Weathers, M.D., Central Medical Clinic, Roanoke Rapids 27870 (1977)
<i>Vice-Councilor:</i>	Robert H. Shackelford, MD, 115 W. Main St., Mt. Olive 28365 (1977)
<i>Fifth District:</i>	Albert Stewart, Jr., M.D., 114 Broadfoot Ave., Fayetteville 28305 (1975)
<i>Vice-Councilor:</i>	August M. Oelrich, M.D., Box 1169, Sanford 27330 (1975)
<i>Sixth District:</i>	J. Kempton Jones, M.D., 1001 S. Hamilton Rd., Chapel Hill 27514 (1977)
<i>Vice-Councilor:</i>	W. Beverly Tucker, M.D., Box 988, Henderson 27536 (1977)
<i>Seventh District:</i>	Jesse Caldwell, Jr., M.D., 114 W. Third Ave., Gastonia 28052 (1975)
<i>Vice-Councilor:</i>	William T. Raby, M.D., 1012 Kings Drive, Charlotte 28283 (1975)
<i>Eighth District:</i>	Ernest B. Spangler, M.D., Drawer X3, Greensboro 27402 (1976)
<i>Vice-Councilor:</i>	James F. Reinhardt, M.D., Cone Hospital, Greensboro 27402 (1976)
<i>Ninth District:</i>	Verne H. Blackwelder, M.D., Box 431, Lenoir 28645 (1976)
<i>Vice-Councilor:</i>	Jack C. Evans, M.D., 244 Fairview Dr., Lexington 27292 (1976)
<i>Tenth District:</i>	Kenneth E. Cosgrove, M.D., 510 7th Ave., W., Hendersonville 28739 (1975)
<i>Vice-Councilor:</i>	Otis Bentley Michael, M.D., Suite 208, Doctors Bldg., Asheville 28801 (1975)

SECTION CHAIRMEN—1974-75

<i>Anesthesiology:</i>	Merel H. Harmel, M.D., Duke University Medical Center, Durham 27710
<i>Dermatology:</i>	Charles M. Howell, Jr., Bowman Gray School of Medicine, Winston-Salem 27103
<i>Family Physicians:</i>	C. O. Plyler, Jr., M.D., 1025 Randolph Road, Thomasville 27360
<i>Internal Medicine:</i>	W. W. Fore, M.D., 1705 W. 6th Street, Greenville 27834
<i>Neurology & Psychiatry:</i>	Marianne S. Breslin, M.D., Duke University Medical Center, Durham 27710
<i>Neurosurgery:</i>	Ira M. Hardy, II, M.D., 1709 W. 6th Street, Greenville 27834
<i>Obstetrics & Gynecology:</i>	C. T. Daniel, Jr., M.D., 1641 Owen Dr., Fayetteville 28304
<i>Ophthalmology:</i>	E. Randolph Wilkerson, Jr., M.D., 1012 Kings Drive, Charlotte 28207
<i>Orthopaedics:</i>	James R. Dineen, M.D., 1616 Medical Center Drive, Wilmington 28401
<i>Otolaryngology:</i>	Nathaniel L. Sparrow, M.D., 3614 Haworth Dr., Raleigh 27609
<i>Pathology:</i>	W. Harley Davidson, M.D., Scotland Memorial Hospital, Laurinburg 28352
<i>Pediatrics:</i>	Eugene B. Cannon, M.D., 135 McArthur St., Asheboro 27203
<i>Public Health & Education:</i>	W. Burns Jones, M.D., 500 Pittsboro Road, Chapel Hill 27514
<i>Radiology:</i>	Julius A. Green, Jr., M.D., 3821 Merton Dr., Raleigh 27609
<i>Surgery:</i>	Robert W. Youngblood, M.D., 1201 Brookside Drive, Wilson 27893
<i>Urology:</i>	P. G. Fox, Jr., M.D., 1110 Wake Forest Road, Raleigh 27604
<i>Students, Medical:</i>	

DELEGATES TO THE AMERICAN MEDICAL ASSOCIATION

DONALD B. KOONCE, M.D., 1833 S. Live Oak Parkway, Wilmington 28401—2 year term (January 1, 1975 to December 31, 1976)

JOHN GLASSON, M.D., 306 S. Gregson St., Durham 27701—2 year term (January 1, 1975 to December 31, 1976)

DAVID G. WELTON, M.D., 3535 Randolph Road, Charlotte 28211—2 year term (January 1, 1974 to December 31, 1975)

EDGAR T. BEDDINGFIELD, JR., M.D., Wilson Clinic, Wilson 27893—2 year term (January 1, 1974 to December 31, 1975)

ALTERNATES TO THE AMERICAN MEDICAL ASSOCIATION

JAMES E. DAVIS, M.D., 1200 Broad St., Durham 27705—2 year term (January 1, 1975 to December 31, 1976)

LOUIS DES. SHAFFNER, M.D., Bowman Gray, Winston-Salem 27103—2 year term (January 1, 1975 to December 31, 1976)

CHARLES W. STYRON, M.D., 615 St. Mary's St., Raleigh 27605—2 year term (January 1, 1974 to December 31, 1975)

D. E. WARD, JR., M.D., 2604 N. Elm St., Lumberton 28358—2 year term (January 1, 1974 to December 31, 1975)

STAFF OF HEADQUARTERS OFFICE

Executive Director—MR. WILLIAM N. HILLIARD

Assist. to Ex. Dir. & Convention Coordinator—MRS. LARUE A. KING

Controller—MR. GARLAND R. PACE

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Winston-Salem

MS. MARTHA VAN NOPPEN, *Acting Assistant Editor*, Winston-Salem

RON W. DAVIS, Ed.D., *Consultant, Medical Education, Regional Medical Program*,
Durham

1974

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CONSTITUTIONAL SECRETARY

The North Carolina Medical Society continues to experience a healthy growth. We have experienced a growth of 175 members in the past year. Again the highest percentage of growth was in the student member category.

The membership figures are as follows:

	December 31, 1972	December 31, 1973
Total Members	4,122	4,297
Life Members	257	286
Student Members	57	108
Intern-Resident Members	20	28

This year has seen serious discussion of some very fundamental issues, which will be difficult to resolve to the satisfaction of all. An effective system of peer review of the quality of care and an effective system of postgraduate education seem to be the most pressing needs arising from these discussions.

The impact of these activities on the membership and the enthusiasm of the individual members will be interesting to observe. My prediction is that the effect will be a positive one in both areas.

E. Harvey Estes, Jr., M.D., Constitutional Secretary

REPORT OF THE EXECUTIVE DIRECTOR

William N. Hilliard

Membership in the North Carolina Medical Society continues to grow at a moderate but steady rate during the 1973-74 Society year. The 1974 Budget, however, reflects a reduction from the 1973 Budget as a result of the bulk of the membership having completed the five year period of increased dues, with the 1974 budget estimates reflecting the adjustment back to the regular annual dues. New members and others who have completed the five year payment of increased dues will continue being billed at the increased amount until their five year payment is completed.

A copy of the Auditor's Report is contained in this compilation of Annual Reports reflecting that all funds and assets of the Society have been properly accounted for on the books of the Society in conformity with generally accepted accounting principles for non-profit organizations. The Audit Report as submitted by A. T. Allen & Company, dated January 18, 1974, stands as a self-explanatory report of my responsibility as Treasurer for the calendar year 1973 and is recommended to you for approval.

The Audit Report also reflects the 1973 management of the *North Carolina Medical Journal* and this portion of the Audit Report is offered as a report on the business affairs of the *Journal* as the Business Manager. A decrease in advertising revenue was experienced during 1973 of approximately \$5,000.00, reflecting a natural trend of pharmaceutical manufacturing firms to advertise more in specialty and national magazines rather than the State magazines.

The Medical Journal Editorial Board. Staff and many members of the State Society were saddened by the

death of Miss Louise MacMillan, Assistant Editor, on March 2, 1974. She had served as Assistant Editor for more than 23 years.

On December 31, 1973, the total membership in the State Society stood at 4,297 as compared with 4,122 on that same date for 1972. As of April 1, 1974, there were 4,059 members of the State Society after taking into account deceased members during the past year and members who have moved out of state. There are, admittedly, a few slow paying members who we do hope to collect dues for within the next few weeks so that we will undoubtedly continue to show a net gain in membership before too much more of 1974 has elapsed. On April 1, 1973, there were 3,912 members of the State Society. Including student and intern-resident members, 207 new members have already joined the Society this year.

Most annual projects and activities of the Society have continued in a manner similar to previous years. Among the more important of the continuing projects is, of course, the arranging and staging of the Annual Meeting of the Society, including two meetings of the House of Delegates, General Sessions on three days, Scientific Specialty Section Meetings, Reference Committee Hearings and related functions of the meeting. Other projects include the Annual Conference of County Medical Society Officers and Committeemen as a Conference on Medical Leadership; the Annual Committee Conclave held at Mid Pines Club in Southern Pines; publication of the *North Carolina Medical Journal* and the *Public Relations Bulletin*; the presentation of First Aid competition trophies to the North Carolina Association of Rescue Squads; a County Medical Society, "Secretary's Check List"; and a two-day Speech Training Session for Society leaders in November; and liaison with many State governmental agencies.

There has been major Society and staff involvement in activities relating to Professional Standards Review Organizations (PSRO) and concern with Federal regulations implementing this feature of Public Law 92-603. A separate organization was formed to deal with this problem, entitled the North Carolina Medical Peer Review Foundation, Inc. Space in the Medical Society building has been leased to that organization and Mr. Dan I. Mainer, a former member of the Headquarters staff, was employed as Executive Director of the Peer Review Foundation.

A member of the Headquarters staff attended a combined total of thirty-one County Medical Society meetings during the year, in addition to two District Medical Society Meetings. The staff stands ready to assist any county medical society in its local efforts insofar as staff time permits.

The State Medical Society is fortunate in having a capable and energetic staff, to assist your Executive Director, all of whom have participated fully and willingly in the various projects assigned to them. In most cases they were completely responsible for various projects, but where more than a single staff person was involved they worked together with a high degree of teamwork.

Mr. Garland Pace, as Controller, administers most

financial affairs of the Society, preparation of Annual Budget estimates, preparation of Technical Exhibit Prospectus for the Annual Meeting as well as assignment of Exhibit space allocation and management of the Exhibit area during the Annual Meeting. He supervises the operation and maintenance of the Headquarters Building, leasing and purchase of office equipment, and liaison responsibility with the building janitorial service and tenants. He is also responsible for staff support for six committees.

Mrs. LaRue King, Assistant to the Executive Director, handles the major preparation of the Annual Meeting Program and supporting materials for the House of Delegates, the compilation of Annual Reports, and meetings of the Executive Council. She handles correspondence relative to the Scientific Exhibits for the Annual Meeting, along with meeting room assignments and special luncheon affairs. She provides the staff support for 10 committees and prepares the schedule for meetings at the Annual Committee Conclave.

Mr. Gene Lane Sauls, Field Representative, continues to assume increasing responsibilities on the staff in both areas of administrative services provided by the Society staff and in Field Service effort. He also is responsible for the staff support of 11 Committees, and has provided administrative services for the Fourth District Medical Society's Annual Meeting. He edits the monthly *Public Relations Bulletin*, is responsible for all audio-visual equipment requirements provided at

the Annual Meeting, and attends national AMA Meetings in his State Society area of responsibility such as the National Rural Health Conference.

Mr. Stephen C. Morrisette, Field Representative works primarily in the field of Legislative activities. This year he has initiated a weekly legislative newsletter to all county society presidents and legislative chairmen. He continues to review all bills introduced in the General Assembly which have any importance to the medical profession and works with the Society Legal Council in contacting physicians about matters being considered by the General Assembly of interest to the membership. He also provides staff support for 14 Committees and for the North Carolina Society of Internal Medicine.

The Administrative Staff meets periodically to discuss projects and activities that each staff member will be involved with or assigned to in order to assist with production and finalization of the various functions scheduled. These meetings enable the staff assistants to be familiar with each other's work schedule in addition to offering assistance to each other and further the teamwork concept within the office.

In closing, the membership should certainly be made aware of my appreciation and gratitude to all the secretarial staff for loyal and efficient efforts on behalf of the Society. They and the staff assistants serve the Society well and do deserve your support and appreciation.

William N. Hilliard, Executive Director

AUDITOR'S REPORT
NORTH CAROLINA MEDICAL SOCIETY
Raleigh, North Carolina

12 Months Ended December 31, 1973

OFFICERS

George G. Gilbert, M.D.	President	Asheville, N. C.
Frank R. Reynolds, M.D.	President-Elect	Wilmington, N. C.
D. E. Ward, Jr., M.D.	First Vice-President	Lumberton, N. C.
Vacant	Second Vice-President	
E. Harvey Estes, Jr., M.D.	Secretary	Durham, N. C.
James E. Davis, M.D.	Speaker of the House	Durham, N. C.
Chalmers R. Carr, M.D.	Vice-Speaker of the House	Charlotte, N. C.
John Glasson, M.D.	Past President	Durham, N. C.
William N. Hilliard	Executive Director- Treasurer	Raleigh, N. C.

Chairman and Members of the Finance Committee
North Carolina Medical Society
Raleigh, North Carolina

Gentlemen:

Pursuant to engagement, we have audited the books and records of the North Carolina Medical Society, Raleigh, North Carolina, for the period beginning January 1, 1973, and ending December 31, 1973, and present herewith our report.

EXHIBITS AND SCHEDULES

In presenting our findings, as the result of the audit, we have prepared four Exhibits and four Schedules, as outlined in the Index, which are attached hereto as a part of this report.

Balance Sheet—Exhibit "A":

The first statement is a list of the Assets, Liabilities, Reserves, and Fund Balances, which we designate as Balance Sheet, December 31, 1973, Exhibit "A". This statement has been divided into two sections. One contains the Current Operating Fund, which represents the Current Assets, Liabilities, and Reserves. The other has been designated as a Capital or Non-Operating Fund containing the office equipment, real estate and capital stock owned and used by the Medical Society.

The Cash on Hand and in Bank is made up of \$5.00 Petty Cash Funds and \$349,059.47 in a checking account at First-Citizens Bank & Trust Company, Raleigh, North Carolina. Also, there was \$103,491.43 in a regular savings account, and \$20,000.00 in a savings bond with the same Bank. There was \$40,000.00 in the local Savings and Loan Associations. The Cash in Bank was verified through reconciliations of the balances as shown by the records of the Medical Society with confirmations obtained independently from the banks. See Schedule 1 of this report for details.

Accounts Receivable—Regular in the amount of \$3,792.92 are shown on the Balance Sheet. The balance represents the total of several uncollected balances due for local advertising in the State Medical Journal, and for miscellaneous receivables.

Accounts Receivable—National Advertising in the amount of \$3,932.98 represent November and Decem-

ber 1973 National Advertising in the State Medical Journal.

Accrued Interest Receivable on three savings certificates totals \$1,159.00.

Air Travel Deposit of \$425.00 is cash deposited with Eastern Airlines for air travel credit cards.

The Medical Society has a Notes Receivable and Deed of Trust, with balance due, of \$190,653.75 from International Developers, Inc., dated December 20, 1972, due each ninety (90) days for ten (10) years, at 7½ percent interest, payments at \$7,330.62 including interest, beginning March 20, 1973. This note came from the sale of land on Raleigh-Durham Highway.

The real estate, capital stock and office equipment and furniture shown on the Balance Sheet in the amount of \$1,345,055.02, is listed in detail in Schedule—2. The items shown represent cost value of the equipment to the Medical Society as no depreciation has been recorded.

Under the "Liabilities" section, we have listed those accounts, expenses, etc., incurred prior to December 31, 1973, for which statements or accounts were rendered or payment was due.

The Accounts Payable—Trade, in the amount of \$11,247.90, represents unpaid accounts at December 31, 1973. Most of these items were paid during the course of the audit.

The \$3,993.00, Dues to be Refunded, represents State dues collected which are refundable to the members. The \$130,795.00, "Due American Medical Association," is 1974 A.M.A. dues collected in 1973. The \$430.00 "American Medical Association Dues in Escrow," represents dues paid to the State Society, but which cannot be remitted to the National Society at the time due to diverse disqualifying reasons. At December 31, 1973, the Society had collected, from members \$8,800.00, for MEDPAC contributions and \$53,428.00 for county dues. These items will be remitted to the respective organization in regular course. The payroll taxes, \$4,299.58, were paid during the course of the audit.

The deferred credits of \$149,737.09 are for payments of \$4,080.00 received on technical exhibits space for the 1974 Convention, and \$144,515.00 on 1974 membership dues, and \$1,142.09 on 1974 tenant's rent.

These remittances were received in 1973, and will be transferred to the income accounts in 1974.

The Reserve accounts set forth on Exhibit "A" are for specific purposes or specific projects, which normally last for periods longer than one year; therefore, special provisions are made to set aside funds for these specified Reserves. A new Reserve for Operating Reserve for \$92,900.00 was established this year. This new Reserve account is intended to eventually equal one year's operating costs.

The Fund Balance section of the Balance Sheet is comprised of two figures, \$249,796.51 being the surplus of the Current Operating Fund at the year-end, and \$1,345,055.02 representing the balance of Capital Fund. It should be observed that all surplus in the Current Operating Fund would not be available for immediate use, since a material amount is made up of the \$190,653.75 Note Receivable from International Developers, Inc.

Statement of Fund Balances—Exhibit "B":

The second statement is an analysis of the changes in Fund Balances during the year and is detailed on Exhibit "B."

Statement of Income and Expenses—Exhibit "C":

A statement showing a budget comparison of the income and expenses for the twelve months period is given in Exhibit "C." This statement is, in effect, a statement of operations for the year, and by examination it may be observed that the Income of \$692,163.14 exceeds the Expenses of \$542,166.79 by \$149,996.35. There was included in the expenses \$3,827.53 in Capital Expenditures, and \$105,200.00 loan repayments. Eliminating these, we show a margin from operations of \$259,023.88.

Comparing with the Budget, we see that actual income was more than anticipated. The main items accounting for this was the interest income received and the large increase in annual dues.

Further comparisons reveal that the total actual expenses were \$93,189.21 less than the budget provision.

Cash Receipts and Disbursements—Exhibit "D":

A statement showing in detail the cash receipts and disbursements of the Society during the year under review is shown on Exhibit "D."

We made a careful analysis of the cash transactions and, where practicable, traced the receipts to their origi-

nal source. Disbursements for expenses were supported by cancelled checks and invoices issued in the regular course of business. We believe the funds have all been accounted for.

GENERAL COMMENTS

A surety bond covering faithful performance of Mr. William N. Hilliard, Executive Director, in the amount of \$50,000.00, is in force, held by the Medical Society and was examined by us. We also examined and found in force a Primary Commercial Blanket Honesty Bond in the amount of \$50,000.00; a fire insurance policy covering fire loss on new building of \$1,000,000.00; all office contents incidental to the use of the Society in the amount of \$70,000.00; glass coverage is included under separate coverage; a Non-Automobile Schedule Policy; a standard Workmen's Compensation and Employer's Liability Policy; a Comprehensive General Liability Policy and Catastrophic Liability Policy; and an Accident Policy on Officers, Delegates, and Staff.

We were extended every courtesy and cooperation during the course of the audit and we experienced no trouble in obtaining the necessary information for this report.

SCOPE OF EXAMINATION AND OPINION

We have examined the balance sheet of the North Carolina Medical Society as of December 31, 1973, and the related statements of income and expense and fund balances for the year then ended. Our examination was made in accordance with generally accepted auditing standards, and accordingly included such tests of the accounting records and such other auditing procedures as we considered necessary in the circumstances.

In our opinion, the accompanying balance sheet and statements of income and expense and fund balance present fairly the financial position of the North Carolina Medical Society at December 31, 1973, and the result of its operations for the year then ended, in conformity with generally accepted accounting principles for non-profit organizations applied on a basis consistent with that of the preceding year.

Respectfully submitted,

A. T. ALLEN & COMPANY
CERTIFIED PUBLIC ACCOUNTANTS

Raleigh, North Carolina
January 18, 1974

NORTH CAROLINA MEDICAL SOCIETY
Raleigh, North Carolina

EXHIBIT "A"
BALANCE SHEET
December 31, 1973

ASSETS:**CURRENT OPERATING FUND:**

Cash on Hand and in Banks—(Schedule—1).....	\$ 512,875.90
Accounts Receivable—Regular.....	3,790.92
Accounts Receivable—National Advertising.....	3,932.98
Accrued Interest Receivable—On Savings Certificates.....	1,159.00
Air Travel Deposit.....	425.00
Notes Receivable—International Developers, Inc.....	190,653.75
TOTAL CURRENT OPERATING FUND.....	\$ 712,837.55

CAPITAL OR NON-OPERATING FUND—(SCHEDULE—2):

Real Estate—Land—Lane and Person Streets, Raleigh, N. C.....	\$ 227,733.90
—Headquarters Building—Raleigh, N. C.....	1,042,394.56
Office Furniture and Fixtures.....	74,726.56
Capital Stock—Common—State Medical Journal Advertising Bureau, Inc.....	200.00
TOTAL CAPITAL OR NON-OPERATING FUND.....	1,345,055.02
TOTAL ASSETS.....	\$2,057,892.57

LIABILITIES, RESERVES, AND FUND BALANCES:**LIABILITIES:**

Accounts Payable—Trade.....	\$ 11,247.90
Dues to be Refunded.....	3,993.00
Due American Medical Association.....	130,795.00
Due American Medical Association—Dues in Escrow.....	430.00
Due County Medical Associations.....	53,428.00
Due MEDPAC.....	8,800.00
Federal and State Income Tax Withheld.....	3,487.81
Payroll Taxes Payable.....	811.77
TOTAL LIABILITIES.....	\$ 212,993.48

DEFERRED CREDITS:

Advance Payments on Technical Exhibit Space at 1974 Convention.....	\$ 4,080.00
Advance Payment on 1974 State Membership Dues.....	144,515.00
Advance Rent from Tenant on 1974 Rental Income.....	1,142.09
TOTAL DEFERRED CREDITS.....	149,737.09

RESERVES:

Reserve for Traffic Liability Safety Program.....	\$ 135.28
Reserve for Section on O & O.....	432.40
Reserve for Mental Health State Conference Programs.....	3,302.87
Reserve for Mental Health Contactorama Programs.....	3,539.92
Reserve for Operating Reserve.....	92,900.00
TOTAL RESERVES.....	100,310.47

FUND BALANCES:

Current Operating Fund—(Exhibit "B").....	\$ 249,796.51
Capital Fund—(Exhibit "B").....	1,345,055.02
TOTAL FUND BALANCES.....	1,594,851.53

TOTAL LIABILITIES, RESERVES, AND NET WORTH.....	\$2,057,892.57
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EXHIBIT "B"
STATEMENT OF FUND BALANCES
December 31, 1973

CURRENT OPERATING FUND:

Balance—January 1, 1973.....		\$ 88,116.47
ADD: Net Profit From Operations.....		259,023.88
LESS: Transfer to New Reserve for Operating Reserve.....	\$ 92,900.00	
Office Furniture and Equipment Transferred to Capital Fund.....	3,827.53	
Construction in Progress—Completion of Drug Authority Rental Space	616.31	(97,343.84)

TOTAL CURRENT OPERATING FUND—TO EXHIBIT "A"..... *\$ 249,796.

CAPITAL FUND:

Balance—January 1, 1973	\$1,340,611.18
ADD: Capital Expenditures From Current Operating Fund.....	3,827.53
Construction in Progress—From Current Operating Fund	616.31

TOTAL CAPITAL FUND—TO EXHIBIT "A" 1,345,055.02

TOTAL FUND BALANCES—DECEMBER 31, 1973 \$1,594,851.19

EXHIBIT "C"
STATEMENT OF INCOME AND EXPENSES
12 Months Ended December 31, 1973

	Budget Provisions	Actual	Difference Over (Under)
INCOME:			
Membership Dues—Current and Prior Years.....	\$ 520,000.00	\$ 548,412.00	\$ 28,412.00
Sales of Journals, Rosters, and Value Scales.....	3,500.00	4,487.56	987.56
Revenue Unexpected	3,000.00	5,531.02	2,531.02
Sales of Technical Exhibit Space.....	10,000.00	10,970.00	970.00
Journal Advertising—Local	10,000.00	8,605.10	(1,394.90)
Journal Advertising—National	35,000.00	29,964.67	(5,035.33)
Commission (1%) from AMA for Dues Collected.....	3,700.00	3,661.10	(38.90)
Commission (1%) from MEDPAC for Dues Collected.....	220.00	213.75	(6.25)
Rental Income	49,936.00	50,627.72	691.72
Interest Income from Note.....	.00	14,977.75	14,977.75
Interest Income from Savings.....	.00	11,503.02	11,503.02
Book Proceeds—"Medicine in North Carolina".....	.00	3,209.45	3,209.45
TOTAL INCOME	\$ 635,356.00	\$ 692,163.14	\$ 56,807.14
EXPENSES:			
Executive Budget:			
A-1 Expense—President	\$ 7,000.00	\$ 6,230.39	\$ (769.61)
A-2 President's Secretarial Assistance	5,000.00	2,458.80	(2,541.20)
A-3 Travel—Secretary	1,000.00	.00	(1,000.00)
A-4 Salary—Executive Director—Treasurer.....	24,000.00	24,000.00	.00
A-5 Travel—Executive Director—Treasurer.....	6,000.00	4,263.80	(1,736.20)
A-6 Executive Office—Secretarial and Clerical Assistance	45,000.00	40,624.57	(4,375.43)
A-7 Executive Office—Equipment and Replacements.....	4,000.00	3,827.53	(172.47)
A-8 Expenses—Executive Office	18,000.00	18,203.40	203.40
A-9 Bonding—(In Effect to 1975).....	.00	.00	.00
A-10 Auditing	2,000.00	2,223.96	223.96
A-11 Taxes—(Salary Tax)	6,440.00	6,575.65	135.65
A-12 Insurance	2,200.00	2,039.50	(160.50)
A-13 Membership Record System and Machine Rental	8,600.00	9,077.68	477.68
A-14 Publications, Reports, and Executive Aids	300.00	295.12	(4.88)
A-15 Salary—Assistant Executive Director.....	17,200.00	17,200.00	.00
A-16 Travel—Assistant Executive Director	3,000.00	2,328.75	(671.25)
A-17 Salary—Assistant to Executive Director.....	12,900.00	12,900.00	.00
A-22 Salary—Controller	15,400.00	15,400.00	.00
A-23 Salary—Field Representative No. 1	12,500.00	12,500.00	.00

* Total Current Operating Fund includes a long-term note receivable from International Developers, Inc., for \$190,653.75 at December 31, 1973; therefore, this figure should be deducted when computing available cash surplus.

	Budget Provisions	Actual	Difference Over (Under)
A-24 Salary—Field Representative No. 2.....	9,600.00	9,600.00	.00
A-25 Travel—Field Representatives No. 1 & 2.....	5,000.00	3,925.58	(1,074.42)
Total Executive Budget	\$ 205,140.00	\$ 193,674.73	\$ (11,465.27)

Journal Budget:

B-1 Publication of Journal.....	\$ 59,800.00	\$ 62,360.79	\$ 2,560.79
B-5 Expenses—Editorial Office.....	850.00	721.22	(128.78)
B-6 Expenses—Business Manager's Office.....	1,000.00	793.54	(206.46)
B-7 Equipment—Business Manager's Office.....	100.00	.00	(100.00)
B-8 Travel for Journal.....	200.00	.00	(200.00)
B-9 Payroll Taxes.....	1,052.00	1,136.41	84.41
B-10 Sales Tax on Journal and Roster Sales.....	2,200.00	2,140.03	(59.97)
B-11 Journal Salaries.....	17,050.00	17,758.00	708.00
Total Journal Budget	\$ 82,252.00	\$ 84,909.99	\$ 2,657.99

Intra-Functional Activity Budget:

C-1 Expenses—Executive Council.....	\$ 4,600.00	\$ 4,146.14	\$ (453.86)
C-2 Expenses—Publication Council Minutes.....	6,500.00	5,703.14	(796.86)
C-3 Expenses—Legislative Committees.....	5,000.00	4,297.04	(702.96)
C-4 Expenses—Maternal Health Committee.....	600.00	600.00	.00
C-5 Expenses—Drug Abuse Committee.....	1,000.00	.00	(1,000.00)
C-7 Expenses—Scientific Exhibits Committee.....	1,225.00	907.80	(317.20)
C-8 Expenses—Mental Health Committee.....	400.00	256.01	(143.99)
C-9 Expenses—Mediation Committee.....	400.00	229.06	(170.94)
C-10 Expenses—Chronic Illness Committee.....	400.00	.00	(400.00)
C-11 Expenses—Committees in General.....	4,500.00	4,337.06	(162.94)
C-15 Expenses—Relative Value Committee.....	600.00	123.50	(476.50)
C-17 Expenses—Student AMA Committee.....	1,060.00	628.65	(431.35)
C-18 Expenses—Disaster Emergency Medical Care Committee.....	600.00	.00	(600.00)
C-20 Expenses—Constitution and By-laws Committee.....	500.00	258.88	(241.12)
C-24 Expenses—Anesthesia Study Committee.....	365.00	314.79	(50.21)
C-30 Expenses—Liaison to Insurance Industry Committee.....	800.00	838.45	38.45
C-31 Expenses—Community Health Committee.....	500.00	386.08	(113.92)
C-36 Expenses—Family Marriage Counseling Committee.....	300.00	5.95	(294.05)
C-37 Expenses—Medicine and Religion Committee.....	350.00	69.00	(281.00)
C-48 Expenses—Medicare Committee.....	200.00	.00	(200.00)
C-49 Expenses—Medical Education Committee.....	1,000.00	.00	(1,000.00)
C-50 Expenses—Comprehensive Health Service Planning Committee.....	250.00	.00	(250.00)
C-51 Expenses—Medical Aspects of Sports Committee.....	1,000.00	814.77	(185.23)
C-53 Expenses—Physicians on Nursing Committee.....	200.00	43.96	(156.04)
C-56 Expenses—President's Communications Program.....	1,200.00	1,121.59	(78.41)
C-58 Expenses—Peer Review Committee.....	200.00	154.52	(45.48)
C-59 Expenses—Health Care Delivery Committee.....	1,000.00	.00	(1,000.00)
Total Intra-Functional Activity Budget	\$ 34,750.00	\$ 25,236.39	\$ (9,513.61)

Extra-Functional Activity Budget:

D-1 Expenses—Delegates to AMA.....	\$ 9,700.00	\$ 6,782.56	\$ (2,917.44)
D-2 Expenses—Conference Dues.....	200.00	232.50	32.50
D-3 Expenses—Woman's Auxiliary.....	4,260.00	4,260.00	.00
Total Extra-Functional Activity Budget	\$ 14,160.00	\$ 11,275.06	\$ (2,884.94)

Public Relations Budget:

E-3 Committee Chairman—Out of State Travel.....	\$ 500.00	\$.00	\$ (500.00)
E-10 Educational Distributions—Materials.....	500.00	21.89	(478.11)
E-11 News and Press Releases.....	200.00	105.08	(94.92)
E-12 Public Relations Bulletin.....	3,500.00	3,761.55	261.55
E-13 State High School Science Fair Program.....	160.00	100.00	(60.00)
E-14 Exhibits and Displays.....	350.00	362.29	12.29
E-15 Conference for Medical Leadership.....	1,500.00	1,392.27	(107.73)
E-17 "Today's Health" Magazine Subscriptions.....	850.00	.00	(850.00)

	Budget Provisions	Actual	Difference Over (Under)
E-18 Collateral Public Relations	500.00	41.90	(458.10)
E-19 N. C. Revenue Squad First Aid Trophies	200.00	117.85	(82.15)
Total Public Relations Budget	\$ 8,260.00	\$ 5,902.83	\$ (2,357.17)
Annual Sessions (119th) Convention Budget:			
F-1 Program Production	\$ 2,000.00	\$ 1,655.96	\$ (344.04)
F-2 Hotel and Auditorium Expense	4,700.00	4,858.03	158.03
F-3 Expenses—Publicity Promotion	600.00	511.64	(88.36)
F-4 Entertainment	1,200.00	1,133.37	(66.63)
F-5 Orchestra and Floor Entertainment	2,500.00	1,983.78	(516.22)
F-6 Guest Speakers	900.00	348.30	(551.70)
F-9 Booth Installation and Supplies	4,500.00	3,938.64	(561.36)
F-10 Projection Expense	1,300.00	550.45	(749.55)
F-11 Badges	250.00	365.00	115.00
F-12 Transactions Reporting Service	2,500.00	2,316.13	(183.87)
F-13 Rental—Extra Facilities	200.00	110.73	(89.27)
F-14 Exhibitors Entertainment	850.00	804.42	(45.58)
F-15 Banquet Expense	200.00	198.93	(1.07)
F-16 Police Security	360.00	360.00	.00
Total Annual Sessions (119th) Convention Budget	\$ 22,060.00	\$ 19,135.38	\$ (2,924.62)
Miscellaneous Budget:			
G-1 Legal Counsel Retainer	\$ 11,300.00	\$ 12,530.85	1,230.85
G-2 Reporting—(Executive Council, Etc.)	2,000.00	1,805.31	(194.69)
G-3 Fifty Year Club—(Pins, Etc.)	300.00	415.28	115.28
G-4 Contingency and Emergency	4,174.00	3,964.27	(209.73)
G-5 Employees Retirement System	19,175.00	18,643.50	(531.50)
G-6 Advalorem Taxes—(Personal Property)	960.00	837.72	(122.28)
G-7 Association of Professions	200.00	200.00	.00
G-10 Expense of Commissioners	1,500.00	1,095.48	(404.52)
G-11 Expenses of Executive Committee	300.00	.00	(300.00)
G-12 Expenses of Officers to National Meetings	2,000.00	4,304.78	2,304.78
G-13 Travel and Maintenance, Expense of Essential Staff— Out-of-State Sessions	1,700.00	2,154.00	454.00
G-14 Sales Tax—"Medicine in North Carolina"00	103.94	103.94
Total Miscellaneous Budget	\$ 43,609.00	\$ 46,055.13	\$ 2,446.13
Headquarters Facility Budget:			
Capital Investments:			
M-1 Application to Construction and or Mortgage Payments—Estimated Available	\$ 162,261.00	\$ 100,000.00	\$ (62,261.00)
M-3 Mortgage Payable on Greenfield Property—7% Interest and Unpaid Balance of \$5,200.00	2,964.00	5,442.64	2,478.64
M-4 Estimated Interest Cost on Mortgage or Construction Funds	7,000.00	415.26	(6,584.74)
Operating Costs:			
M-5 Utilities	13,800.00	14,223.44	423.44
M-6 Insurance	1,700.00	1,754.00	54.00
M-7 Taxes	16,700.00	16,183.95	(516.05)
M-8 Water	500.00	363.40	(136.60)
M-9 Janitorial Services	15,000.00	12,900.00	(2,100.00)
M-10 Grounds Maintenance	1,000.00	984.73	(15.27)
M-11 Building Repairs and Maintenance	1,200.00	1,045.24	(154.76)
M-12 Heating, A C Repairs and Maintenance	3,000.00	2,664.62	(335.38)
Total Headquarters Facility Budget	\$ 225,125.00	\$ 155,977.28	\$ (69,147.72)
TOTAL EXPENSES	\$ 635,356.00	\$ 542,166.79	\$ 93,189.21
SUMMARY:			
TOTAL INCOME			\$ 692,163.11
LESS: EXPENSES:			
Executive Budget	\$ 193,674.73		
Journal Budget	84,909.99		
Intra-Functional Activity Budget	25,236.39		

	Budget Provisions	Actual	Difference Over (Under)
Extra-Functional Activity Budget.....		11,275.06	
Public Relations Budget.....		5,902.83	
Annual Sessions (119th) Convention Budget.....		19,135.38	
Miscellaneous Budget		46,055.13	
Headquarters Facility Budget.....		155,977.28	542,166.79
EXCESS OF INCOME OVER EXPENSES			\$ 149,996.35
ADD: Capital Expenditures From Current Funds			109,027.53
NET MARGIN FROM OPERATIONS			\$ 259,023.88

EXHIBIT "D"**CASH RECEIPTS AND DISBURSEMENTS**

12 Months Ended December 31, 1973

CASH ON HAND AND IN BANKS—JANUARY 1, 1973		\$ 264,079.05
ADD: CASH RECEIPTS:		
Income From Operations—(Exhibit "C").....	\$ 692,163.14	
Decrease in Accounts Receivable—Regular.....	1,885.00	
Decrease in Accounts Receivable—National.....	752.49	
Receipts on Notes Receivable—International Developers, Inc.—Principal.....	14,346.25	
Increase in Refunds Payable.....	2,309.00	
AMA Dues Collected.....	413,275.00	
County Dues Collected.....	157,966.00	
MEDPAC Dues Collected.....	24,740.00	
Increase in Payroll Taxes Unremitted.....	446.28	
Advance Payments—Technical Exhibit Space—1974.....	4,080.00	
Advance Payments—State Membership Dues—1974.....	144,515.00	
Advance Payments—Rent from Tenant—1974.....	1,142.09	
(LESS): Accrued Interest Receivable on Savings Certificates	(1,159.00)	
TOTAL CASH RECEIPTS		1,456,461.25
TOTAL FUNDS TO ACCOUNT FOR		\$1,720,540.30
CASH DISBURSEMENTS:		
Expenditures From Operations—(Exhibit "C").....	\$ 542,166.79	
Disbursements—Construction in Process—1973.....	616.31	
Accounts Payable—Trade—12/31/72—Paid in 1973.....	23,441.20	
Decrease in AMA Escrow Funds.....	60.00	
AMA Dues Remittances.....	364,875.00	
County Dues Remittances.....	136,753.00	
MEDPAC Dues Remittances.....	20,970.00	
Advance Payments—Technical Exhibit Space—1973— Transferred to 1973 Income.....	4,560.00	
Advance Payments—State Membership Dues—1973—Transferred to 1973 Income.....	125,470.00	
(LESS): Accounts Payable—Trade—12/31/73—Unremitted	(11,247.90)	
TOTAL CASH DISBURSEMENTS		\$1,207,654.40
CASH ON HAND AND IN BANKS—DECEMBER 31, 1973		512,875.90
TOTAL FUNDS ACCOUNTED FOR		\$1,720,540.30

SCHEDULE—1

CASH ON HAND AND IN BANKS (INCLUDING SAVINGS)
December 31, 1973

FIRST-CITIZENS BANK & TRUST COMPANY—RALEIGH, N. C.:

Checking Account—Number 12-03-643.....	\$ 349,059.47
Savings Account—Number 0861010544	103,491.43
Savings Bond—Number 39270—N.....	20,000.00
	<u>\$ 472,550.90</u>

FIRST FEDERAL SAVINGS & LOAN ASSOCIATION—RALEIGH, N. C.

Certificate of Deposit—Number 141,851.....	20,000.00
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RALEIGH SAVINGS & LOAN ASSOCIATION—RALEIGH, N. C.:

Certificate of Deposit—Number 5931.....	20,000.00
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PETTY CASH FUND—OFFICE.....	75.00
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TRAVEL ADVANCE FUND—FIELD REPRESENTATIVE.....	250.00
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TOTAL CASH	<u>\$ 512,875.90</u>
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SCHEDULE—2

SCHEDULE OF CAPITAL ASSETS
December 31, 1973

Quantity	Item	Date	Cost	Quantity	Item	Date	Cost
OFFICE FURNITURE AND FIXTURES:							
1	Steel Filing Cabinet		\$ 71.75	1	Hand Truck		13.5
2	Gray Steel Filing Cabinets..		103.00	1	Section Steel Shelving.....		123.6
1	Four Drawer Steel			1	Scriptor 13" Elite Electric		
	Filing Cabinet		78.03		Typewriter No. 9709767		311.8
1	Remington Rand Electric			4	No. 8 B 51 Five		
	Adding Machine		215.01		Drawer Files		401.7
1	Metal Storage Cabinet		78.28	1	Electric Pencil Sharpener ..		34.9
1	Metal Filing Cabinet		92.76	1	Feeder Unit for		
1	Metal File and Sections.....		68.55		Addressograph		936.5
2	Typewriters—Large			1	Scriptor Electric		
	Type (Bulletin)		321.23		Typewriter No. 1089421..		366.1
1	Metal File and Frames.....		93.07	2	Five-Drawer Files—Gray ..		200.9
1	Portable Lectern		29.93	1	Storage Cabinet		83.1
1	Metal File		114.33		I.B.M. Equipment:		
1	Five-Drawer Letter File.....		122.78	17	Control Panels		374.2
2	Five-Drawer Files		245.56	1	Sorter Rack		49.7
1	A. B. Dick Offset			5	Sets Manual Wire		
	Duplicator		3,204.53		Complements		177.3
2	Four-Drawer Durable Files		61.70	1	Twenty-Drawer Card File		284.9
1	Postage Mailing Machine....		855.70	1	Control Panel Cabinet....		71.5
1	Book Case Section			1	Mosler Fire-Proof File—		
	No. 813 Walnut		29.26		Four-Drawer		319.3
3	Letter Size Files		103.72	3	Cory Five-Drawer		
1	TU-24 Star Tube Roll File..		40.00		Letter Files		290.9
1	122 H Steel Cart W/3			1	Cosco Secretarial Chair.....		30.8
	Shelves		35.76	1	Combo Binding Machine....		46.9
6	Four-Drawer Letter Size			1	Model L-H Letter Opener..		58.7
	Files		199.31	1	18" Pendaflexer—		
1	Electric Projection Pointer..		77.15		Two-Drawer		43.7
1	Toledo Postage Scale			7	Four-Drawer Files		223.5
	(Used)		154.50	1	Underwood Electric		
1	Three Section Book Case		137.61		Typewriter—700		
1	Divisumma 24 Calculator..		627.79		TW No. 9694676.....		334.7
1	Walnut Dictionary Stand. .		67.07	1	Projection Pointer		97.0
4	Side Chairs		73.05	2	Shelving Units		66.9
1	Premier Ream Cutter		259.47	1	Eight Station Collator—		
1	No. 1900 Addressograph		500.00		Paper Gatherer		346.5
1	Carrying Case for			1	3 M Portable Compact		
	Adding Machine		18.49		Copier		69.9
1	Four-Drawer Letter File		173.66	1	Tu-DROR Pendaflexor		
1	Four-Drawer No. 24-A				File		63.8
	File Cabinet		41.95	1	Electrosumma 20 Adding		
1	Remington Typewriter				Machine No. 6638949....		184.8
	No. 3064244		388.90	1	Dual Purpose Hand Truck..		47.5

Quantity	Item	Date	Cost	Quantity	Item	Date	Cost
1	F & E Checkwriting Machine		115.88	22	No. 1086 Howe Folding Tables	3/24/71	2,640.00
1	Desk—Walnut Finish		118.97	4	2530 Bench—DG	3/24/71	940.36
1	Remington Electric Typewriter No. 634800..		424.01	3	19-12 Pot Cover	3/24/71	49.59
1	Remington Electric Typewriter No. 635838..		424.00	1	67 BC Sofa	3/24/71	613.87
1	Four-Drawer File (Dr. Styron)		88.60	2	65 BC Chairs	3/24/71	487.13
1	Used Copying Machine—A. B. Dick No. 675		1,000.00	1	252 Coffee Table	3/24/71	242.46
1	Supply Cabinet		37.00	3	19-12 Pot Cover	3/24/71	49.59
1	Storage Cabinet		37.00	1	8623 Ash Tray	3/24/71	12.67
1	Metal Letter File with Lock		61.60	150	1601-G Stacking Chair	3/24/71	2,295.75
1	Storage Cabinet		37.00	8	1600-1 Dolly	3/24/71	132.25
1	Royal Typewriter No. 4132-506		133.31	4	309 F-2 Table	3/24/71	262.30
1	Four-Drawer Metal File		69.49	16	1601 Stacking Chair	3/24/71	238.05
1	Two-Drawer Metal File		18.36	2	72 UBC Chairs	3/24/71	138.32
1	Supply Cabinet		75.00	4	72 US-BS Chairs	3/24/71	349.37
1	Metal Storage Cabinet		57.29	6	1514 WRC Desks	3/24/71	1,384.28
1	Folder Machine and A. B. Dick Stand		397.88	1	1519 WRC Table Desk	3/24/71	215.47
1	Model DLS Screen		32.45	1	1546 WRC Secretarial Desk	3/24/71	367.55
1	Record Player		101.25	6	541 WRC Credenzas	3/24/71	1,776.66
1	Microphone and Stand		19.40	1	541 WRC Credenza	3/24/71	333.38
1	Slide Projector—With Case		94.47	1	541 Credenza	3/24/71	409.43
1	Lectern Mike		56.85	8	72 UBC Chairs	3/24/71	585.25
1	Camera & Flash		88.98	6	72 UBC Chairs	3/24/71	457.09
1	Metal File		95.79	2	72 UBC Chairs	3/24/71	179.64
2	Four-Drawer Files		194.47	8	10 N-10 Waste Baskets	3/24/71	193.97
1	Underwood Scriptor Electric Typewriter No. 21-8721980		337.64	8	2 W Letter Trays	3/24/71	163.11
1	Crestline Deluxe Projector		79.26	2	72 US—BS Chairs	3/24/71	188.74
1	Carri-Voice and Revere Tape Recorder No. 3001 312		480.00	1	1503 WRC Desk	3/24/71	312.45
2	8 B 51 Gray File Cabinets		236.66	2	72 UBC Chairs	3/24/71	141.63
1	8 B 51 Gray File Cabinet		100.57	1	1590 Table	3/24/71	234.19
1	Five-Drawer Gray File Cabinet		100.48	4	68S—BS Chairs	3/24/71	662.40
1	Bell & Howell Projector		175.00	1	8623 Ash Tray	3/24/71	12.67
2	Four-Drawer File		63.86	1	10 N-10 M Waste Basket	3/24/71	24.25
2	Cory Five-Drawer Files		228.66	1	2-W Letter Tray	3/24/71	20.39
1	Olympia Electric Typewriter No. 27-494032		431.05	1	19-9 Pot Cover	3/24/71	8.82
1	Steel File		88.27	1	1503 WRC Desk	3/24/71	312.45
2	Four-Drawer Files		63.86	1	541 WRC Credenza	3/24/71	285.44
1	Portable Lectern		29.67	2	72 UBC Chairs	3/24/71	138.31
1	Eight Yard Dempster Dumpmaster			1	704 BC Sofa Bed	3/24/71	472.52
	Sanco Corporation	3/19/71	528.37	1	65 ABC Chair	3/24/71	262.58
4	Floor Ash Trays—Duk-It—ROS	3/24/71	96.00	1	2511 Table	3/24/71	159.80
3	Dual Receptacle Duk-It	3/24/71	117.00	1	10 N-10 M Waste Basket	3/24/71	24.25
5	Duk-It Black Letter Trays	3/24/71	37.50	1	2-W Letter Tray	3/24/71	20.39
42	No. 1605 Ash Trays	3/24/71	126.00	19	1258 DS Chairs	3/24/71	2,946.30
6	Duk-It Waste Baskets	3/24/71	66.60	12	1255 Chairs	3/24/71	1,509.92
9	Duk-It Calendars and Bases	3/24/71	21.60	2	544 WR Wall Cabinets	3/24/71	548.85
8	No. 1607 Ash Trays—Duk-It	3/24/71	31.20	1	19-12 Pot Cover	3/24/71	16.53
3	Duk-It Ice Water Pitcher & Tray	3/24/71	126.00	2	65 BC Chairs	3/24/71	436.43
6	No. 6023 Chairs—Serapi Blue—Navaho Fabrics	3/24/71	497.88	1	2562 WRBC Table	3/24/71	67.77
2	No. 6023 Chairs—Soot Black—Navaho Fabric	3/24/71	165.96	4	72 USBS Chairs	3/24/71	349.35
10	No. 6055 UA Chairs—Ebony—Navaho Fabric	3/24/71	1,940.40	1	Frigidaire Refrigerator—Tuttle	4/15/71	349.68
				1	Frigidaire Range	4/15/71	246.17
				2	Royal Metal 30 x 75	4/30/71	228.50
				1	Conference Table	4/30/71	104.22
				6	Alma Book Cases	4/30/71	495.72
				4	Wall Poles	4/30/71	31.44
				2	File Units	4/30/71	175.22
				1	Sliding Door Cabinet	4/30/71	53.35
				6	Alma Shelves	4/30/71	47.17
				1	Cory Library Table	4/30/71	195.77
				6	All Steel Black Desks—A. Williams	4/30/71	1,602.54
				1	All Steel Black Table 36 x 36	4/30/71	66.31
				1	Lectern	4/30/71	68.22
				1	Chalkboard	4/30/71	67.06
				1	Conference Table—Oil Walnut Finish	4/30/71	3,982.50
				1	Lectern—Oil Walnut Finish	4/30/71	239.99

Quantity	Item	Date	Cost
2	Tables—White—163 F	4/30/71	100.29
12	1258 DS Chairs— Red Fabric	4/30/71	1,863.78
3	Clocks—HM Black Case— Storr Sales	4/30/71	139.21
	Draperies—Weaver Textile	5/28/71	6,620.21
7	Art Metal Bookcase Sections—Storr Sales	6/25/71	551.06
1	Vogel Peterson Costumer, Wall Shelf & Coat Hangers	6/25/71	80.42
1	Chair and Table—ROS	6/25/71	152.98
1	Toro Lawn Mower—Flythe	7/09/71	124.58
2	1-W Letter Trays—D.G.	7/09/71	20.59
2	72 USBS Chairs	7/09/71	201.32
1	10-N Waste Basket	7/09/71	17.73
1	2562 WR BC TABC	7/09/71	78.06
4	Bookcase Sections and one End Panel No. 2118— Storr Sales	9/07/71	342.31
6	No. 800 Walnut Oil Shelves—E & B	10/21/71	63.65
4	Lockers—Gray Finish	12/23/71	186.70
1	560 R Pedestal Desk and Chair—Storr Sales	11/23/71	395.30
1	Twenty-Drawer Card File—Clyde Rudd	2/11/71	210.73
1	Drain Board for Printing Room—Montgomery- Green	5/12/71	72.10
1	Control Panel Cabinet— Tab Products	5/12/71	87.86
1	Edison-Voicewriter— T. A. Edison Ind.	7/19/71	1,548.46
1	File Cabinet—W. B. Bunn	11/23/71	150.00
1	Bates Electric Stapler— # 56	3/08/72	72.28
2	IBM Selectric II Typewriters	5/15/72	1,268.80
1	IBM Selectric II Typewriter	12/08/72	634.40
2	IBM Selectric II Typewriter	4/26/73	1,268.80
2	Stencraft Storage Cabinets	8/17/73	133.12
1	Bookcase—Oil Walnut	9/13/73	101.09
5	Panasonic Tape Recorders	10/08/73	389.64
1	Ricoh Electronic Calculator	12/21/73	462.80
1	Nu-Arc Light Table— (Lay-Out)	11/28/73	182.00
1	IBM Electric Typewriter	12/31/73	717.60
1	Envelope Detacher	12/31/73	281.33
1	Sonyo Recorder	12/31/73	291.15

**TOTAL OFFICE
FURNITURE AND
FIXTURES**

\$ 74,726.56

REAL ESTATE:

Land—Lane and Person
Streets, Raleigh, N. C.—
(Schedule—3)

227,733.90

New Headquarters Facility
Building, Raleigh, N. C.
—(Schedule—4)

1,042,394.50

OTHER ASSETS:

Capital Stock—State
Medical Journal
Advertising Bureau, Inc.

200.00

TOTAL CAPITAL ASSETS—

TO EXHIBIT "A"

\$1,345,055.00

SCHEDULE—3

**SCHEDULE OF BUILDING SITE COSTS—
PERSON AND LANE STREETS, RALEIGH**

December 31, 1973

Land Purchase—Person and Lane Streets— Raleigh, North Carolina	\$ 175,000.00
Legal Services	825.00
Survey and Map of Property	.00
Architect Service	954.00
Appraisal Fees	200.00
Photos	69.00
Cleaning Lot	75.00
Lot—217 North Bloodworth Street— Raleigh, North Carolina	14,252.50
Lot—222 North Person Street— Raleigh, North Carolina	36,358.30

TOTAL TO SCHEDULE—2 \$ 227,733.90

SCHEDULE—4

NEW HEADQUARTERS FACILITY BUILDING

December 31, 1973

Worthy and Company—Consulting Services	\$ 23,234.45
J. A. Edwards—Engineering	699.78
Geotechnical Engineering Company— Soil Borings	1,143.50
Miscellaneous—Maps, Printing, Lot Cleanings, Etc.	377.99
Grading Services, Inc.— Demolition of Buildings	5,000.00
G. Milton Small—Architects	59,857.53
Carl A. Mims—General Contractor	728,678.29
Stahl-Rider, Inc.— Heating and Air Conditioning	121,225.19
Bryant-Durham Electrical Contractors— Electrical	86,317.00
Mechanical Associates—Plumbing	21,366.82
Froehling & Robertson, Inc.— Structural Testing	2,763.25
Various—To Complete Construction on Drug Authority Rental Space	616.31
Tenant Reimbursements	(8,885.55)

TOTAL TO SCHEDULE—2 \$1,042,394.50

REPORT FROM THE WOMAN'S AUXILIARY OF THE NORTH CAROLINA MEDICAL SOCIETY

"Service to Medicine and Humanity"

The year of 1973-74 began our second fifty years. We know we cannot rest on our past achievements but must continue to recognize the everchanging conditions of our society and respond to them. By doing this, our Auxiliary will continue to grow and develop so that at our one hundredth year, we will be a stronger and more viable organization. It has been my distinct privilege and pleasure to have been President at the initiation of the next half century of service. In my travels to County and District meetings, I have observed genuine warmth and enthusiasm among our members. They are engaged in many projects that bring credit to the medical profession. The work of doctor's wives in North Carolina compares very favorably with those of other states across the nation and I am indeed proud to be their representative for this year.

Dr. George Gilbert, President of the North Carolina Medical Society, has been most generous in the giving of his time to speak to us and to advise me in regard to Auxiliary matters. The Auxiliary is most grateful and appreciative for all the support given by the Medical Society as a whole. The Headquarters Staff has been cooperative and helpful and very prompt in complying with our requests. We have enjoyed using the Auxiliary Office for several committee meetings during the year as well as the Council Room for our Mid-Winter Conference. Dr. Gloria Graham, Chairman of the Advisory Committee, has been extremely interested and enthusiastic over Auxiliary accomplishments and has been most helpful with her guidance and suggestions.

Our theme for this year is "Service to Medicine and Humanity." We have projected our theme into the areas of health and service in our communities.

Our first Program Planning Workshop was held in conjunction with our Annual Convention. It was designed to aid and assist incoming County Officers in running their years' work and carrying out the years' theme. We specifically focused on six areas of interest. They were: AMA-ERF, Health Manpower, Safety, Nutrition, Blood Donor, and Legislation.

In the Fall, a series of Regional Workshops were held in Hickory, Fayetteville, and Greenville to again emphasize our areas of interest.

AMA-ERF—The American Medical Association Education and Research Fund continues to be our only philanthropic endeavor sponsored by the Woman's Auxiliary to the American Medical Association. Over the past eleven years, the Auxiliary has been increasingly responsible for the designated funds returned to North Carolina. In its initial year, 1962, the Auxiliary contributions that were designated, represented 6 per cent of the funds returned to North Carolina medical schools. In 1973, this figure had increased to 51 per cent. Various methods of fund raising have been used besides direct contribution. This year a cookbook, *The Roaming Board*, is the most popular item. It was put together by the wives of the Officers and Board of Trustees of the American Medical Association and derewritten by the Board itself. As of January 1, 1974,

have become part of "Project Credit" where all donations from North Carolina received in the AMA-ERF office in Chicago, will go on record for our

Auxiliary. With this project, we hope some of our hard work will receive National recognition. Donations to the Davison Fund at Duke University and the Co-Founders Club at the University of North Carolina can now also be donated to AMA-ERF and earmarked for these funds with our Auxiliary receiving the credit. At the writing of this report, donations totaled \$10,070.24. It is hoped that we can pass the \$11,000.00 mark.

This year, a handbook for fund raising, compiled by our state AMA-ERF Chairman, Mrs. Joe (Jean) Frazer of Greensboro, was so well received by the WA-AMA, that they reproduced it and distributed it on a National level.

At our Mid-Winter Conference, Mrs. Cliff (Frankie) Moore, Jr. of Rome, Georgia, our Southern Regional AMA-ERF Chairman, gave an informative presentation. She also brought with her items for display that could be sold with the proceeds going to AMA-ERF.

HEALTH EDUCATION—Several counties have purchased the film, *VD—A New Focus*, and made it available to their school systems at a junior high level. Some have been very successful while others continue to press for its use. Our state Health Education Chairman, Mrs. Edwin (Martha) Martinat, is in the process of completing a survey that will give us a good idea just what kind and how much health education is being taught in the schools and by whom. The report is not as yet complete.

Mrs. John (Betty) McCain wrote an article for *M.D.'s Wife* entitled "The Sick Physician Needs Help." Betty is the Mental Health Chairman for the WA-AMA.

CHILD ABUSE—This has been one of our main areas of interest with several county Auxiliaries presenting programs on it. At our Mid-Winter Conference, Dr. Minta Saunders spoke to us about their program in Greensboro.

BLOOD DONOR PROGRAM—Our involvement in the Blood Donor Program continues to be an area of frustration and we have not been able to come up with a satisfactory answer. We do have many Auxiliary members who volunteer their time to this program.

HEALTH MANPOWER—The Auxiliary has sponsored many Health Fairs. These allow young children to appreciate thru the senses of touch and feel, the examination equipment found in a physician's office and hospital setting. At times we have worked with other related groups who also explain their equipment and the role which they play in providing health care.

LEGISLATION—As there continue to be many pieces of legislation dealing with health affairs, the Auxiliary has attempted to keep abreast of these proposals. We encourage all our members to support candidates sympathetic to the cause of Medicine. We are currently in the middle of a LEGS Alert, (Legislative Effort Group System) where everyone is asked to write to their congressmen in regard to Phase IV.

HEALTH SERVICES—Some of our Auxiliaries are becoming active with other community groups in the "Meals on Wheels" project. It provides one hot nutritious meal a day to a shut-in or elderly person.

Due to the increase and interest in cycling, some emphasis has been put on Bicycle Safety as well as Safety on the Streets. This pertains to safer procedures to follow while on the streets.

In addition to the projects listed and enumerated

consist of a strong program of continuing medical education which will revolve around a central theme which crosses specialty lines.

4. Such programs will be planned and executed in cooperation with the faculties of the Medical Schools.
5. Because of the length of the Annual Meeting and the *required* sessions, some specialty sections must meet concurrently with the General Sessions. It was felt that this could be worked out to prohibit a conflict of interest.

The Committee on Arrangements was in accord with the foregoing and farther recommended to the Executive Council that Memorial Services be united with a Prayer Breakfast, to be planned through the cooperative efforts of the Memorial Committee and the Committee on Medicine and Religion. The Auxiliary will be invited to participate.

Josephine E. Newell, M.D., Chairman, Commission III

PROFESSIONAL SERVICE COMMISSION

Six committees met on schedule and had a busy and productive year. The Blue Shield committee had its regular meetings, which were open to all, and its subcommittee on claims adjudication was highly effective. The committee on Hospital and Professional relations met and approved in principle the N. C. Society of Internal Medicine's request to study methods of improving medical records, recommended guidelines regarding professional remuneration of interns and residents, and requested a legal ruling on the rights and hazards of obtaining blood alcohol levels. The committee to work with the Industrial Commission met at the Conclave and recommended May 1975 as the time for updating the N. C. Workman's Compensation Fee Schedule, with subsequent updating every two years thereafter. The Insurance Industry committee met periodically, adjudicated a large number of claims, recommended that insurance carriers provide maternity benefits for unmarried minor females, voted to oppose Senate Bill No. 932 which would eliminate "coordination of benefits" in group insurance contracts in effect in North Carolina, and appointed a subcommittee to define and develop guidelines for the determination of "custodial care." The committee on Physical and Vocational Rehabilitation nominated Dr. William B. Hall, Jr., Fayetteville, N. C., as Physician of the Year for the Governor's Committee on Employment of the Handicapped. The Committee Advisory to Crippled Children's Program met, and its consensus was that the State Board of Health should draft certain criteria and guidelines, noting the number of physicians, as well as specialties, and set forth certain criteria by which an institution could be measured in order to receive certification for payment. The full reports of these committees will appear elsewhere in this compilation. The support from and the cooperation of these committees are greatly appreciated.

W. Howard Wilson, M.D., Commissioner

PUBLIC RELATIONS COMMISSION

All of the committees of the Public Relations Commission met in Southern Pines during the Committee

Conclave in September 1973. Several of the committees have met since then. With few exceptions each of the meetings were well attended and productive, as indicated by the reports of the committee chairman listed separately. Some of the activities of the committee are outlined below.

Medical-Legal Committee: Julius A. Howell, M.D., Chairman

1. Plans were made to distribute questionnaires regarding medical conditions in jails to county authorities.
2. Members of the legal and medical professions were encouraged to follow the *Medico-Legal Code of Understanding* for problems that arise in the malpractice area.

Eye Care and Eye Bank Committee: Paul McB. Abernathy, M.D., Chairman

1. Assistance was given the Department of Social Services in management of some of the professional reimbursement problems associated with the provision of optical services to North Carolina recipients under Title XIX.
2. Recommendations were made to the Committee on Relative Value Study that as soon as possible more descriptive procedures be added to the RVS.

Committee Liaison to the N. C. Pharmaceutical Association: Charles W. Byrd, M.D., Chairman

1. Assistance in an advisory capacity was given Paid Prescriptions, Inc. in North Carolina as employed by the Department of Social Services to administer the Medicaid program for prescriptions in North Carolina.
2. In cooperation with the N. C. Pharmaceutical Association and the N. C. Board of Pharmacy, a program was undertaken to assure continued high quality prescription priorities in North Carolina.
3. Support was given behind House Bill 156 to require labeling of prescriptions.

Committee on Disaster and Community Medical Care: George A. Watson, M.D., Chairman

1. Assistance was given in an advisory capacity through an expanded committee with representatives from other interested state agencies, to the new program by the Emergency Medical Services Division with the Dept. of Social Services.
2. Expansion of the Good Samaritan Law was recommended to cover all emergency situations.

Committee on Association of Professions: Thomas G. Thurston, M.D., Chairman

1. Happenings of joint professional concern were reviewed by the committee and recommendations were made as to how we can more effectively work together.

Committee on Legislation: H. David Bruton, M.D., Chairman

1. Continuing surveillance was provided state and national health legislation and reported to the Executive Council.
2. Effective efforts were made to present the official position of organized medicine to the legislature.

Committee on Community Medical Care: J. Kempton
nes, M.D., Chairman

1. Endorsement was given the Governor's Rural Health Program as an example of an experimental model health care system. Close followup evaluation was recommended to determine effectiveness.
2. A position paper on the *Need for More and Better Distribution of Primary Care Physicians* was prepared with assistance of other concerned groups for presentation to the House of Delegates.

Committee on Public Relations: John L. McCain, M.D.,
Chairman

1. An AMA Medical Leadership Seminar was conducted with Dr. Marshall Redding, M.D., as Program Coordinator.
2. Conference for Medical Leadership was sponsored on the topic of "Practicing Physician Pressure Point" at the Headquarters Office Building in Raleigh.
3. To help increase physician productivity, a program on "Train Your Own Assistant" was prepared and made available to the membership.

For detailed accounts of committee actions and deliberations, please refer to the respective committee chairman's report.

I would like to commend the committee chairmen and the headquarters staff for the excellent service performed and the leadership given and accomplishment achieved in the Public Relations Commission.

John L. McCain, M.D., Commissioner

PUBLIC SERVICE COMMISSION

It is rather difficult for me to know exactly what to write in my first report as Chairman of Public Service Commission. I did meet with all of the nine (9) committees and I was deeply impressed with the dedication of each chairman and with the obvious concern of the members of these committees. Summaries of each committee's work will be printed elsewhere in this issue so I shall not repeat what each chairman has said. I think that my main job is to recognize the tremendous amount of work which these committees have done.

The President of North Carolina Medical Society appointed an Ad Hoc Committee on Mental Health to review the current salary schedule for physicians within the mental health system and make recommendations as to how to make these salaries competitive and enable the department to recruit qualified physicians into the system. It was pointed out by Dr. Zarzar that salaries available for physicians working in the mental health system were well below what the physician could earn in private practice. He requested that the State Medical Society support a 30 per cent increase for physician's salaries within the mental health system as proposed by the Department to the Advisory Budget Commission of the legislature. He also pointed out that Medicaid receipts now go to the general fund. He felt that these receipts should go back to the mental health system in order to provide funds to up-grade services provided. It was pointed out by Dr. Lowenbach that 80 per cent of the psychiatrists in the United States practice in towns where the population is 500,000 yet they treat only 8

per cent of the patients. It was resolved that "base salaries for physicians in the mental health system should be raised by 15 per cent and that an additional 15 per cent should be paid to attract physicians to less popular positions."

It was also the consensus of the committee that President, George G. Gilbert, M.D. should send a questionnaire to all members of the North Carolina Medical Society asking them if they would be willing to work as a consultant in the mental health system, and what they would consider as a reasonable daily fee for such work. This was done by the President and as of the time of this writing only one reply has been received.

Philip G. Nelson, M.D., Commissioner

DEVELOPING GOVERNMENT HEALTH PROGRAMS COMMISSION

The Committees under this Commission have had a very active year. Each met during the September Conclave with good attendance. The members of the Committees were interested. Special guests with information necessary for the Committees added valuable input into the sessions of the Committees.

The Committees with their respective Chairman currently on the Commission are:

1. Comprehensive Health Service Planning, Committee On—Robert C. Moffatt, M.D.
2. Medicare, Committee On—William T. Raby, M.D.
3. Peer Review, Committee On—M. Frank Sohmer, M.D.
4. Social Services Programs, Committee On—James S. Mitchener, M.D.
5. Health Care Delivery, Committee On—Patrick Kenan, M.D.

The activities of these Committees is contained in reports submitted by the Chairmen and will be found in the compilation of reports.

The Committee on Peer Review activities again merits particular mention. The report of M. Frank Sohmer, Jr. M.D. who is Chairman of the Medical Society Committee is also head of the North Carolina Peer Review Foundation reflects the constant activity of this group.

The increasing communication between the Social Services Programs Committee and officials of the department of Social Services reflects a spirit of cooperation which has gradually developed. This is particularly helpful to both parties in problem cases.

The Committee on Comprehensive Health Services Planning is in the process of developing new guidelines for the various State planning areas to outline the planning areas where physicians are most needed and should be involved. When these guidelines are developed, they are to be presented to the Executive Committee for review and further disposition.

The Committee on Health Care Delivery is awaiting to study the results of a survey questionnaire concerning accessibility to medical care which was taken in Durham-Orange Counties. If the results show a clear pattern or develop valid trends, the Committee will recommend that a similar study be done statewide. It was felt strongly by the members of this Committee that the State Society must address itself to the problems of accessibility to health care.

John A. McLeod, Jr., M.D., Commissioner

REPORT ON COMMITTEES

COMMITTEE ON AUXILIARY & AMA-ERF

No report.

COMMITTEE ON ANESTHESIA STUDY

The Committee on Anesthesia Study convened on the evening of September 28, 1973 at the Mid Pines Club in Southern Pines, North Carolina. Chairman Dr. Bechtoldt reported on the continuing progress of the new Medical Examiner system. Of the twenty one deaths considered at the meeting to be related to anesthesia in some way, several deaths were picked up by the Medical Examiner system and not by the Death Certificate system. On the other hand, there were several operating room deaths not reported to the Medical Examiner.

Therefore, it was felt that the dual system should be continued. The Medical Examiner system adds to the number of reported operating room deaths, while the Death Certificate system adds the dimension of Recovery Room and Intensive Care Unit deaths related to an anesthetic as these deaths might not be reported to the Medical Examiner.

It was emphasized that all of the hospitals in North Carolina should be reminded again of the Medical Examiner system. This will be done through (1) the questionnaires routinely sent out, (2) the "Public Relations Bulletin," and (3) a letter by Dr. Page Hudson sent through Mr. Hilliard's office to all of the hospital administrators.

There followed at the meeting individual consideration of cases.

Albert A. Bechtoldt, Jr., M.D., Chairman

COMMITTEE ON ARRANGEMENTS

The Committee met in Southern Pines on September 27, 1973, with excellent attendance. Three major topics were considered and acted upon. The committee recommended that the Auxiliary and the Society jointly sponsor a Memorial Service, combined with a Prayer Breakfast. The Committee endorsed the idea of devoting two general sessions to coordinated postgraduate educational programs, prepared by the faculty of the medical schools. The Committee discussed the expressed desire of the Society for a Thursday night to Sunday meeting, and how this could be accomplished in the face of prior commitments of the hotel management for available days. Some support emerged for a September meeting, and this possibility will be further explored.

E. Harvey Estes, Jr., M.D., Chairman

COMMITTEE ON ASSOCIATION OF PROFESSIONS

Opportunity has been afforded the North Carolina Association of Professions this past year, to gain the attention of KEY State Agency Heads and legislators by expressing views and concerns of our professional practitioners which have been passed on to our members.

Beginning with our 1973 Tenth Anniversary Meeting last March, Senator Herman Moore of Mecklenburg was invited to speak to the Board of Directors on his Tax Exemption proposals. The Association members

were primarily concerned with the INTANGIBLE TAX LAWS and stated their reasons for promoting exemption from the current law. Senator Moore took note of this request and attempted to include this in his bills, then before the General Assembly. No action was taken during the 1973 session, and these issues were promised to come before the 1974 session.

David Flaherty, Secretary of the State Human Resources Department, received many questions from the group when he addressed the membership meeting during the afternoon session. He agreed that private and public agencies and leaders working together to provide service and protection to the citizens of North Carolina can do a better job more efficiently and effectively, at a less cost to the taxpayer. Flaherty, being a business man knows the importance of business and professional leader support for state government programs, and he was pleased to hear practitioners speak out for and against specific tax-funded services—that could best be carried out by private enterprise.

It is with pride that the Association recognized Dr. John S. Rhodes at the 1973 annual meeting with a SPECIAL AWARD for his ten years of leadership and service to the objectives and purposes of NCAP. Representative Bundy of Pitt County was the dinner speaker.

During the summer and fall, all professional licensing boards were called before a sub-committee, appointed by the 1973 General Assembly, to report their finances; regulations; methods for licensing; and appointments or selection of board members. All 32 separate funded licensing boards were given a written questionnaire to complete and called in for public hearings. Several questions were common to all Boards: fees, board appointments; duties of board members; compensation for members; rules and restrictions, if any, for licensing investigative services performed on behalf of the boards and tenure of office for members.

The results of these hearings were reviewed with Representative Foyle Hightower, of Anson, chairman of the sub-committee charged with the responsibility for reviewing all licensing boards, at an Association meeting held in Charlotte on October 4th. At that time NCAP members were quite open with their support of the present operation of the professional licensing board and urged that they remain as "peer member groups" and allowed to serve the purposes for which they were created and charged by the professional practice acts.

In February, 1974—a battery of bills were introduced by the Hightower sub-committee and referred to the House Finance Committee. All NCAP members have received a copy of these bills. Results are not known at this point. NCAP has been recorded by the committee as objecting to one or more of these bills and is awaiting further opportunity to be heard.

The March 6, 1974 Annual Meeting will be another forum at which time these bills will be reviewed.

Officers who have served the Association the past year are:

President: William B. Gibbs, P.E., Burlington
Vice-President and president-elect: A. W. Smith, D.V.M., Farmville
Second Vice-President: B. Cade Brooks, P.Ph., Fayetteville

Secretary: E. A. Pearson, D.D.S., Raleigh
 Treasurer: Thomas G. Thurston, M.D., Salisbury
 Immediate Past-President: John F. Wicker, A.I.A.,
 Greensboro

Mrs. John B. Chase, chairman of the House Health Committee, has been invited to address the dinner meeting on March 6, 1974 of the 1974 annual meeting to be held in Raleigh at the Velvet Cloak Inn. Mrs. Chase has played an important role in many of the study efforts concerning professional manpower; financing of health services; and educational training programs. The association is honored by having her accept its invitation for March 6th.

New Officers will be elected and installed March 6th with Dr. A. W. Smith to serve as the 12th President for 1974-75.

Thomas G. Thurston, M.D., Chairman

COMMITTEE ON AUDIO-VISUAL PROGRAMS

The Committee on Audio-Visual Programs met during the Committee Conclave in September.

An interesting audio-visual program has been planned for the Annual Meeting in May for Monday, May 20th 10:00 a.m. to 12:00 Noon p.m. and 2:00 p.m. to 5:00 p.m.; and Tuesday, May 21st, 9:00 a.m. to 12:00 Noon and 2:00 p.m. to 5:00 p.m. Members of the Committee will serve as moderator each session.

The full program of films will be listed in the official program copy, and this program will also be distributed to the membership in the April issue of the Public Relations Bulletin.

G. P. Henderson, Jr., M.D., Chairman

COMMITTEE ON ARCHIVES OF HISTORY—NCMS

No report

COMMITTEE ON BLUE SHIELD

Your Blue Shield Committee held five scheduled meetings of the full membership during the past year. These meeting dates were established in advance; and the entire Society membership notified of the meeting schedule through bulletin of the Headquarters Office had informed that any member could present matters for Committee consideration. In addition the Claims Review Subcommittee met monthly and there were several called meetings of Ad Hoc Committees appointed to consider special issues.

Vacancies in the pediatrics, obstetrics and surgical sections were unfilled through the summer months due to the resignation of a surgical member for health reasons, and the inability of representatives from the pediatric and obstetric sections to serve on the Committee. The Executive Council, at the September meeting, appointed Doctor J. H. Monroe for the obstetric section, Doctor William W. Farley for the pediatric section, Doctor Marshall Morris as a surgical consultant, Doctor H. V. Bullard, Jr. as an internist consultant, and Doctor John Wooten as an orthopedic consultant.

For the future, your committee respectfully suggests that nominees for Blue Shield Committee membership be contacted prior to election by the House of Dele-

gates to determine that conflicts of responsibilities do not prevent willingness to serve.

The meetings of the Committee during the past year were characterized by progress in understanding between members of the Society and Blue Cross and Blue Shield. During the March meeting of the Committee, representatives from the North Carolina Society of Internal Medicine presented a statement of concerns. Blue Cross and Blue Shield representatives, including Corporation physician trustees, responded to their concerns; and assured these doctors and the Committee that the Corporation had and would continue to direct its sincere effort to work cooperatively to find viable solutions to problems and seek better communication with physicians and subscribers. Discussions between the North Carolina Society of Internal Medicine and the Corporation through the channel of the Blue Shield Committee have continued throughout the year. A special Ad Hoc Literature Committee has been appointed under the chairmanship of Doctor C. A. Hoffman, Jr. to meet with appropriate staff members of the Corporation and committee members and consultants. This is to help development of Blue Cross and Blue Shield booklets and literature that most accurately describe to subscribers the benefits, limitations, and exclusions of their coverage.

The correlation of the opinions, advice, and decisions of this and previous Blue Shield Committees has kept the formal activities of the Committee to a bearable level. One reasonably successful telephone conference was tried in December as an experiment for claims review in case the fuel shortage restricts travel to meetings. Specialty members have actively served in a liaison capacity between the Committee and specialty groups to help resolve problems involving new or unusual services. Among many matters involving problems or special consideration were the establishment of benefit guidelines for private duty nursing services, psychiatric care involving paramedical personnel, administration of inhalation therapy benefits, duplication of pre-surgical diagnostic services, the proliferation of diagnostic, laboratory panel screening, and utilization of laboratory services. Committee actions continue to contribute to Blue Shield policy decisions and maintain effective communications between the Corporation and the Medical Society.

Serving on the Claims Review Subcommittee were Doctors Vatz, Robertson, McCutcheon, Johnston, Langley, and Morris. During the twelve meetings approximately 315 cases were formally adjudicated, from which important precedents and general guidelines relating to charges and customary medical practice emerged and were referred to the full Committee for final determination. Claims were reviewed at the request of individual physicians or the Corporation when there was a question about the type and amount of benefits applicable, or when a procedure or service was provided for which benefits had not been established.

Committee members and consultants have given generously of their time serving as advisors in problems relating to their specialty. There have been approximately 1,500 communications with the Corporation about customary medical care and Blue Shield professional benefits. The three year terms enable members of the Committee to become familiar with the problems of physicians and the Corporation and aware of the

rapid developments and changes of common concern in the delivery and funding of health services. However, the diversity and scope of activities of major concern to the medical profession result in heavy responsibilities and time demands on the Chairman. Some problems and issues require more than one year to resolve. In the future, it may be desirable for the Society to allow flexibility of tenure to permit a member to serve two years as chairman, while a designated vice chairman is developing the experience and training to succeed him.

North Carolina Blue Cross and Blue Shield has been cooperative and responsive at all times and the Committee is grateful for the active support of Committee functions by Mr. Thomas A. Rose, President, and to Mr. K. G. Beeston, Vice President of Blue Shield Activities, for his continued help in the capacity of secretary and staff support.

The Committee is appreciative of the interest, participation, and frequent meeting attendance of Doctor G. G. Gilbert, President; Doctor F. R. Reynolds, President Elect; Doctor John Glasson, Past President, Doctor Howard Wilson, Commissioner, and Mr. William N. Hilliard, Executive Director of the North Carolina Medical Society.

David S. Johnston, M.D., Chairman

REPORT OF PHYSICIAN TRUSTEES NORTH CAROLINA BLUE CROSS AND BLUE SHIELD, INC. TO NORTH CAROLINA MEDICAL SOCIETY

The year 1973 was a very eventful one for North Carolina Blue Cross and Blue Shield, Inc. Two significant events having much to do with the future of North Carolina Blue Cross and Blue Shield, Inc., occurred during the year. The first was the assumption of the duties of President by Mr. Thomas A. Rose. The second was the long anticipated move into the new Service Center on the Chapel Hill-Durham Boulevard.

The Board of Trustees met monthly with Physician Trustees as well as other Trustees having almost perfect record of attendance. Dr. David S. Johnston, Chairman of the Blue Shield Committee, and Dr. Frank R. Reynolds, President-Elect of the North Carolina Medical Society, met with the Board as ex officio members and contributed greatly to the deliberations of the Board.

A Corporate Plan for 1974 was completed in mid-December 1973 under the guidance of President Rose and after much time and effort at all levels of the Corporation. The Corporate Planning Committee developed and implemented a two-phase corporate planning process. This process required that each division formulate a statement of assumptions on anticipated events, as based on the purpose and objectives of the Corporation, and prepare a statement of programs for 1974 charting directions the Corporation will take.

During the last two weeks in July 1973 approximately 850 Durham and Chapel Hill employees moved into the new Blue Cross and Blue Shield Service Center on the Chapel Hill-Durham Boulevard. Nine of eleven former offices in Durham and Chapel Hill were closed. This long-needed facility enables the Corporation to establish and maintain more effective and economical

administration of an expanding business, which grew by close to 400,000 members since 1967. Even more important, the Service Center, as its name implies, enables the Corporation to improve and expand service to subscribers, doctors and hospitals, and the public we serve.

The Blue Cross and Blue Shield Service Center was officially dedicated Friday, October 19, 1973. President Thomas A. Rose presided at the ceremony on the east plaza that was attended by some 300 invited guests and hundreds of employees. Principal dedication speaker was Marshall I. Pickens, Chairman of the Trustees of The Duke Endowment.

The Blue Shield Activities Division issued a new Doctors' Manual in late 1973 to replace one which had been well received and much used since 1969. Professional Relations Representatives distributed copies of the manual to doctors and clinics at workshops and during personal visits to doctors' offices. The manual is intended to acquaint doctors with information about Blue Shield benefits, identification card explanation, and claim form preparation and in so doing improves and expands our service to our subscribers.

Enrollment in the Teachers and State Employees group increased to 140,000 certificates in 1973 with over 273,000 participants. Two important benefit changes were an increase in in-hospital medical benefits under High Option from \$5 per day to 100 percent UCR and an increase in surgical benefits and in-hospital medical benefits under Low Option to 80 percent UCR.

During 1973 the Corporation processed a record high of 1,880,528 Blue Cross and Blue Shield claims. This reflected an increase of 234,759 claims. A record benefit payment of \$158,513,167 was recorded for Blue Cross and Blue Shield claims. These plus Medicare Part A and CHAMPUS claims brought total claims to 2,345,400 claims and paid \$290,744,047 in benefits under all underwritten and administered programs.

Additional detailed information concerning operations of Blue Cross and Blue Shield of North Carolina is available by reference to the Corporate annual report.

The Claims Processing Task Force continued its work throughout the year to alleviate service problems relating to claims processing. Efforts were concentrated in major areas such as prompt and accurate processing, thereby reducing inventories, and establishing an ongoing program of quality control. The Blue Shield Activities Division continues to establish a line of communication and to carry out an ongoing liaison between the Corporation and the medical profession through planned personal contact and prompt Corporate attention and response to questions raised by the medical profession.

The cooperation of all trustees, Physicians, Hospital Administrators and Public members as well as Management was excellent. The Board is especially grateful to Senior Vice President Rogers C. Wade who served as Acting President prior to the arrival of President Rose. Mr. Wade retired on August 10, 1973, after 28 years of dedicated service to Blue Cross and Blue Shield.

President Rose has already established contacts with many members of the Medical Society as well as with public leaders and subscribers throughout the State.

The Physician Trustees are grateful for the privilege

serving on the Board and have been accorded utmost cooperation by management and other trustees.

Frederick A. Blount, M.D., Roy S. Bigham, M.D., James E. Davis, M.D., H. Fleming Fuller, M.D., Alfred T. Hamilton, M.D., Marvin N. Lymberis, M.D., Joseph B. Stevens, M.D., Kenneth D. Weeks, M.D.

COMMITTEE ON CANCER

The Committee on Cancer met on September 27, 1973 in Southern Pines with excellent committee attendance and with the support of ten resource people whose help was invaluable.

Dr. Isa Grant, State Board of Health, reported the annual summary of the cancer three-day diagnostic and day treatment program. She reported that the 19 cancer clinics and 30 multiphasic screening clinics have performed a total of 23,366 Pap smears with 44 cases of cancer detected in addition to other findings. The State Board of Health performed 109,000 Pap smears of which 475 were positive. Statistics for Pap smears performed by private pathologist were not available.

Mr. Jim McCormick reported for the Central Cancer Registry and an annual symposium held in March. The Registry was depicted as a going concern with its annual report due in the next few weeks. Five primary cases were concentrated on in this report. There are over 22,300 cases in the registry.

Mrs. Edna Raynor showed transparencies of the breast cancer data report. It was pointed out that in spite of advancement in therapy we still have the same percentage of female breast cancer deaths that we had 10 years ago with the rate going up but the percentage remaining stable.

Five hospitals were granted approval for participation in the Cancer Diagnostic and Treatment Program. These were Martin General Hospital, Williamston, Chowan County Hospital, Gordon-Crowell Hospital, Lincolnton, Hawba Memorial Hospital, Hickory and the Sea Level Hospital was approved for Diagnostic Program only.

After a report by Dr. Grant on Certified Home Health Agencies a motion was made recommending that the State Medical Society emphasize and call attention to the value of the State Board of Health's Certified Home Health Agency Services so that physicians in different counties, particularly the sparsely settled areas could be informed of the various functions and encourage the use of the Certified Home Health Agency Services which can be made available to the physicians in the State. Also, that the State Society might send out notices particularly to the small counties to make the doctors aware of these services and what can be done to help them.

In response to continued inquiry about the liberalization of guidelines in regard to chemotherapy, a committee chaired by Dr. Jim Maher of Goldsboro, was appointed to study this subject with the hope that some definitive action could be taken.

Dr. Simmons Patterson reported for the Regional Medical Program that it would be viable until June 30, 1974 and its future after that is uncertain. Certain programs of the Regional Medical Program related to cancer are continuing and have been very successful.

Dr. Warren Cole reported for the N. C. Division of the American Cancer Society. He particularly re-

ported the Uterine Task Force Program and the continuing efforts to establish a breast cancer study program at Duke Hospital. This effort is coordinated and supported by the American Cancer Society.

It was reported that the N. C. Cancer Institute in Lumberton had 65 beds with average occupancy of 62 and has recently purchased new equipment. They have a full time medical director and administrator and are doing a splendid job in supplying terminal care.

It was reported by Dr. Max Scheibel that the Governor's Cancer Commission expired on June 30, 1973 and its future was uncertain. Ten thousand copies of the cancer resource booklet had been printed and distributed with excellent reception.

Lewis S. Thorp, M.D., Chairman

ANNUAL CHAMPUS REPORT TO STATE MEDICAL SOCIETY

The Dependent's Medical Care Act of 1956 became the founding block for the Civilian Health and Medical Program of the Uniformed Services, a comprehensive health program commonly known as CHAMPUS. The CHAMPUS provides coverage to the dependents of active duty personnel, retirees and their dependents, and dependents of deceased personnel who seek medical care outside of military facilities.

However, the scope of the CHAMPUS has been expanded. Through the passage of the Veterans Health Care Expansion Act of 1973 (P.L. 93-82), the spouse or child of a veteran with a total permanent disability (service connected) or the surviving spouse or child of a veteran who dies from a service connected disability is entitled to receive hospital and medical care benefits. The law authorized the Veterans Administration to provide for care in the private sector, as well as in VA facilities.

The law became effective on September 01, 1973 and a contract between the Department of Defense (OCHAMPUS) and the Veterans Administration has been signed. In effect, the VA decided to contract with the Department of Defense to provide civilian medical care to its beneficiaries using OCHAMPUS and the CHAMPUS System of Fiscal Agents. The Veterans Administration has named the new program CHAMPVA (Civilian Health and Medical Programs of the Veterans Administration).

The CHAMPUS Program is administered by Blue Cross and Blue Shield of North Carolina, the fiscal agent for the Office of Civilian Health and Medical Program of the Uniformed Services. Claims are processed in accordance with the usual, customary and reasonable fee concept with payments made to the physician or to the patient. The usual, customary and reasonable concept, as administered under the CHAMPUS, has continued to be widely accepted by North Carolina physicians with few exceptions. However, if a physician does not desire to participate in the CHAMPUS Program or does not want to be subject to the usual and customary allowance determinations, our office can reimburse the patient in an amount not to exceed that which would have been paid to the physician.

Present trends indicate a reduction in the population of dependents of active duty servicemen. However, the number of retired military personnel and dependents will likely increase since the Armed Services are

allowing for early retirement. Secondly, the emergence of CHAMPUS increases the number of beneficiaries eligible to receive civilian medical care. More important, however, is the drastic cut back of active duty physicians who are "base connected." Therefore, it appears that care of dependents and retired service personnel in North Carolina will continually be the responsibility of the practicing physician and other medical community services.

In its seventeenth year as fiscal administrator for the CHAMPUS Program, Blue Cross and Blue Shield of North Carolina made payment of \$4,549,341.25 to physicians in the state for 48,348 cases. This represents an average payment of \$94.10 per case for outpatient and inpatient care. Since 1957 CHAMPUS has made payment of \$27,483,380.00 for 284,111 cases—a significant factor in support of free choice medical care in North Carolina.

We wish to express our sincere appreciation and thanks to the North Carolina Medical Society for their continued support and guidance in the administration of this Program.

COMMITTEE ON CHILD HEALTH AND INFECTIOUS DISEASE

The Child Health Committee met at Pinehurst on Friday, September 28, 1973. A considerable number of topics were discussed and two recommendations were referred to the Executive Council.

The status of sickle cell screening was discussed by Dr. Ted Scurletis. It was generally agreed that this is a very sensitive area and progress must be very carefully planned and implemented.

Dr. Will London discussed early and periodic screening, diagnosis and treatment of Medicaid patients. There was considerable response from most of the committee members regarding this, and all agreed that intensive efforts at the state level should be made to clarify and help implement this program.

A trial immunization program against Hemophilus Influenzae, Type B and Neisseria Meningitis Group C Meningitis in Mecklenburg County was mentioned by Dr. O. F. Roddey. After discussion on this, Dr. Paul Glezen made the recommendation and it was unanimously agreed that Hemophilus Influenzae Meningitis be made a reportable disease. This is for the two-fold purpose of helping to decide on the use of the vaccine on a state-wide basis, and because of the frequency and sequelae of this serious disease.

Dr. Ted Scurletis discussed regional care centers for neonates and their transportation to these centers, and the Committee recommended that the principle of regionalization of newborn care as being presented by Dr. George Brumley to the Committee on Legislation be pursued and implemented.

O. F. Roddey, Jr., M.D.

COMMITTEE ON CHRONIC ILLNESS, TB, AND HEART DISEASE

The Committee on Chronic Illness, TB, and Heart Disease met on September 26, 1973 at the Annual Convocation of Committees in Southern Pines, North Carolina.

I. Dr. W. G. Steininger, Medical Director, McCain

Hospital, discussed "Current Trends in the Management of Tuberculosis Patients: Shorter Duration of Hospitalization: Emphasis on Home Care." Dr. Steininger also indicated that North Carolina has the 12th highest new tuberculosis case rate in any state in the nation, 22% ahead of the national average. During the last three years, there has been no appreciable decline and therefore we have to realize that tuberculosis in North Carolina is still a major problem. In view of this case finding remains an important endeavor and in order to avoid increased spread of disease, active treatment programs should be maintained under the best possible circumstances and supervision. The following recommendation is therefore made to the Executive Council:

WHEREAS IN CALENDAR YEAR 1972 REPORTS WERE MADE TO PUBLIC HEALTH AUTHORITIES OF 996 NEW ACTIVE CASES OF TUBERCULOSIS WITH SIXTY PERCENT BEING OVER THE AGE OF FORTY-FIVE AND SEVENTY PERCENT BEING MALE, 130 REACTIVATIONS OF TUBERCULOSIS AND 113 DEATHS ATTRIBUTED TO TUBERCULOSIS IN NORTH CAROLINA,

AND WHEREAS IN 1972 NORTH CAROLINA HAD THE TWELFTH HIGHEST NEW ACTIVE TUBERCULOSIS CASE RATE IN THE NATION (19.1 PER 100,000 POPULATION COMPARED TO U.S. RATE OF 15.8 PER 100,000), THE CHRONIC ILLNESS COMMITTEE OF THE N. C. MEDICAL SOCIETY RECOMMENDS:

1. A RENEWED EFFORT TO IDENTIFY AND BRING TO TREATMENT CASES AND POTENTIAL CASES OF TUBERCULOSIS AMONG THE POPULATION.
2. THAT WHERE TREATMENT IS INDICATED EVERY ATTEMPT BE MADE TO SELECT, WITH APPROPRIATE CONSULTATION AND LABORATORY INVESTIGATION AS NECESSARY, AN ADEQUATE REGIMEN OF ANTITUBERCULOSIS DRUG THERAPY FOR A MINIMUM OF TWO YEARS OF UNINTERRUPTED TREATMENT IN THE CASE OF ACTIVE OR PROBABLY ACTIVE DISEASE.
3. THAT THE INITIAL PHASE OF TREATMENT OF ACTIVE CASES COVERING THE PERIOD OF POSSIBLE INFECTIOUSNESS SHOULD IN MOST CASES TAKE PLACE IN A HOSPITAL HAVING THE NECESSARY MEDICAL, LABORATORY AND SUPPORTING FACILITIES FOR FULL EVALUATION AND FORMULATION OF OPTIMUM DRUG THERAPY PLANS.
4. THAT RESPONSIBILITY FOR SUPERVISING THE CARRYING OUT OF TREATMENT AT HOME AND EPIDEMIOLOGICAL INVESTIGATION OF CASES INCLUDING THE REPORTING OF NEW CASES BE ACTIVELY SHARED WITH PUBLIC HEALTH AUTHORITIES.

N. B. THE TUBERCULIN SKIN TEST IS RECOMMENDED AS THE INITIAL SCREENING

PROCEDURE OF CHOICE IN TUBERCULOSIS CASE FINDING.

The Recommendation was seconded and carried unanimously)

I. The Committee discussed the "Statement Regarding Preventive Use of Isoniazid" as a public health measure that was adopted by the Committee and presented to the Executive Council last year. Reference Committee #1 recommended and the House of Delegates approved that the report be referred back to the Chronic Disease Committee for re-evaluation.

The Committee discussed the recommendation at length and decided to re-submit the recommendation as again to the Executive Council as they agree unanimously with its contents:

THE COMMITTEE ON CHRONIC ILLNESS ENDORSES THE PREVENTIVE USE OF ISONIAZID IN THOSE SITUATIONS WHERE, IN THE OPINION OF THE INDIVIDUAL'S PHYSICIAN, OR ONE OR MORE PHYSICIANS EXPERIENCED IN TUBERCULOSIS, SUCH WOULD BE IN THE BEST INTEREST OF THE HEALTH OF THE INDIVIDUAL, HIS FAMILY OR COMMUNITY FROM THE POINT OF VIEW OF PREVENTING FURTHER SPREAD OF INFECTION. THOSE INCLUDED MAY FALL INTO ONE OF THE FOLLOWING GROUPS:

1. INFANTS AND YOUNG CHILDREN WITH A HISTORY OF HOUSEHOLD EXPOSURE TO AN INFECTIOUS CASE OF TUBERCULOSIS.
2. RECENT CLOSE HOUSEHOLD OLDER CHILD AND ADULT CONTACTS OF AN INFECTIOUS CASE OF TUBERCULOSIS WHO HAVE SIGNIFICANT TUBERCULIN HYPERSENSITIVITY.
3. PREVIOUSLY UNTREATED CHILDREN TWENTY YEARS OF AGE AND UNDER WHO HAVE SIGNIFICANT TUBERCULIN HYPERSENSITIVITY.
4. CERTAIN RECENT TUBERCULIN CONVERTERS OF ANY AGE WHO HAVE SIGNIFICANT TUBERCULIN HYPERSENSITIVITY.
5. CERTAIN MEDICAL SITUATIONS INVOLVING UNCONTROLLED DIABETES MELLITUS, SILICOSIS, AND THOSE WITH PEPTIC ULCER ABOUT TO UNDERGO PLACED ON CORTICOSTEROID THERAPY HAS SIGNIFICANT TUBERCULIN HYPERSENSITIVITY AND FOR THOSE WHO ARE PLACED ON CORTICOSTEROID THERAPY.
6. CERTAIN PREVIOUSLY UNTREATED OR INADEQUATELY TREATED, INACTIVE OR QUIESCENT CASES OF TUBERCULOSIS.
7. THE COMMITTEE RECOMMENDS IN EACH SITUATION THAT THE RISK OF KNOWN SIDE EFFECTS OF ISONIAZID BE EVALUATED AGAINST THE POSSIBLE ADVANTAGES TO THE INDIVIDUAL AND COMMUNITY BEFORE DECIDING TO INSTITUTE THERAPY. AND THAT WHEN ISONIAZID IS PRESCRIBED, PE-

MADE OF PATIENTS RECEIVING IT IN ORDER TO DETECT OCCURRENCE OF ANY ADVERSE SIDE EFFECTS AS EARLY AS POSSIBLE.

THE ABOVE SHOULD RECEIVE THE CONSIDERATION AND ENDORSEMENT OF LOCAL MEDICAL SOCIETIES.

(Recommendation was seconded and unanimously carried)

III. A progress report on Home Health Care was given by Dr. Thomas D. Long and Mr. Jim Boehm, Chairman of the Home Health Services Committee. In general, the Home Health Care programs are well received and in September, 1973, there were 50 Home Health Agencies in 63 counties. The majority of these are based in the Health Department, but there are six in general hospitals, 10 are independent, and one is in the Department of Social Services. Mr. Boehm discussed with the Committee DHS Form 1500, the Patient's Discharge/Referral Form. The use of this form has been very satisfactory; it has also been well accepted by physicians and nurses. The committee made the following recommendation to the Executive Council:

THE COMMITTEE ON CHRONIC ILLNESS REVIEWED AND APPROVED THE "REFERRAL AND TREATMENT" FORM (DHS-1500) OF THE DEPARTMENT OF HUMAN RESOURCES, DIVISION OF HEALTH SERVICES, AS WAS PRESENTED.

THE COMMITTEE ON CHRONIC ILLNESS RECOMMENDS TO THE EXECUTIVE COUNCIL THAT THE NORTH CAROLINA MEDICAL SOCIETY CONTINUE TO ENDORSE HOME HEALTH SERVICES AND RECOMMEND THE DEVELOPMENT AND EXTENSION OF HOME CARE TO AREAS NOT HAVING THESE SERVICES AT THE PRESENT TIME.

(Both these recommendations were seconded and carried unanimously)

IV. Mr. Ernest Phillips, Special Assistant, Medicare-Medicaid Program, Division of Health Services, gave a report on New Federal Regulations Affecting Nursing Homes:

- a. Uniform Standards for Skilled Nursing Facilities under Medicare and Medicaid
In the past, Medicare certified "extended care facilities" and Medicaid certified "skilled nursing home." The new amendment establishes a single "skilled nursing facility" definition and a single set of health, safety, environmental, and staffing standards for such institutions. A single determination of compliance for Medicare would also qualify a facility for Medicaid.
This is effective July 1, 1973.
- b. Implementation of ICF Programs
While not a part of the 1972 amendments, the implementation of an intermediate care facility program began in North Carolina on July 1, 1973. ICF care is paid for only under Medicaid but the inclusion of ICF payments does add a different type of care to our state programs. It is intended to serve those patients who need some skilled nursing services but not on a 24-hour basis. An ICF

provides skilled nursing 8 hours per day, 7 days per week on the day shift.

c. Reorganization of State Government:

As a part of reorganization, all licensure and certification of health facilities and services have been placed in a new division of the Department of Human Resources—the Division of Facility Services. This Division will handle all matters involving health facilities. Previously these functions were scattered throughout five or six state agencies."

V. Dr. Abram I. Van Horn, UNC School of Medicine, Department of Hospital Administration, gave a brief report on "The Role of the Medical Director in Long-Term Care Facilities":

He reminded the committee of the requirements under Federal jurisdiction with respect to physicians services in long-term care institutions. The health care must continue under the supervision of a physician and the facility must have a physician available to furnish necessary medical care in the case of an emergency.

The AMA this past year decided to hold several seminars throughout the country on the subject of the "Medical Director in Long-Term Care Facilities." Dr. Van Horn passed out reports of what came out of these conferences. The Committee discussed the desirability to have a Medical Director for Long-Term Facilities and came up with the following recommendation for the Executive Council:

THE COMMITTEE ON CHRONIC ILLNESS RECOMMENDS TO THE EXECUTIVE COUNCIL THE N. C. MEDICAL SOCIETY ENDORSE THE PRINCIPLE THAT LONG TERM CARE FACILITIES IN NORTH CAROLINA EMPLOY THE SERVICES OF A PHYSICIAN TO SERVE AS MEDICAL DIRECTOR.

(Recommendation seconded by Dr. Long and carried unanimously)

Dr. Van Horn discussed the AMA qualifications of the function of a Medical Director in a Long-Term Care Facility. The following recommendation was made to the Executive Council:

THAT THE NORTH CAROLINA MEDICAL SOCIETY ENDORSE THE "GUIDELINES FOR A MEDICAL DIRECTOR IN A LONG TERM CARE FACILITY" AS ADOPTED BY THE A.M.A. AND THAT COPIES OF THESE "GUIDELINES" BE FORWARDED TO THE N. C. DEPARTMENT OF HUMAN RESOURCES AND TO THE N. C. HEALTH FACILITIES ASSOCIATION WITH THE RECOMMENDATION THAT THESE RESPECTIVE AGENCIES AND ORGANIZATIONS TAKE SIMILAR ACTION OF ENDORSEMENT.

(Recommendation seconded by Dr. Long and carried unanimously)

VI. The Committee reviewed the Chronic Illness Committee Guidelines as presented to them before the meeting and accepted them as written.

Dirk Verhoeff, M.D., Chairman

COMMITTEE ON COMMUNITY MEDICAL CARE

The Committee on Community Medical Care has had a busy year. During the summer of '73 we helped

draw up a program that would take residents in primary care programs out into communities which are in need of such care. They would practice with established physicians and hopefully would be inspired to set up permanent practices of their own there. Money was appropriated by the last legislature for this purpose.

At our September meeting and subsequently we worked out details of a proposal which would rotate medical students in the schools of our state out into communities across the state. They would precept under a chosen panel of physicians in primary care practice. A subcommittee did much of the work of this project.

Another subcommittee is working on a position paper to be presented to the North Carolina Medical Society on the need for more and better distributed primary care physicians in North Carolina.

Mr. Jim Bernstein who is heading the Governor's Office of Rural Health Services Program met with us in September and a dialogue was established which has continued concerning the progress of this program.

Implementation and development of all of these plans will have our continued concern and attention during the coming year.

J. Kempton Jones, M.D., Chairman

COMMITTEE ON COMPREHENSIVE HEALTH SERVICES PLANNING

(Report not received April 10, 1974)

COMMITTEE ON CONSTITUTION & BYLAWS

Annual Report to be presented in the HOUSE OF DELEGATES Sunday, May 19, 1974, Cardinal Ballroom, Pinehurst Hotel, Pinehurst.

Henry J. Carr, Jr., M.D., Chairman

COMMITTEE ON CREDENTIALS

Certification of Delegates and report to the HOUSE OF DELEGATES at opening session, Sunday, May 19, 1974, Cardinal Ballroom, Pinehurst Hotel, Pinehurst.

Charles B. Wilkerson, Jr., M.D., Chairman

ADVISORY COMMITTEE TO THE CRIPPLED CHILDREN'S PROGRAM

The only action to come before the Advisory Committee to the Crippled Children's Program occurred at the September 26th Annual Meeting held at the M. Pines Club, Southern Pines, N. C. There was only one person absent from the meeting.

Details of the Meeting are present in the minutes of the meeting on file in the Medical Society office.

No other business activities were performed by the committee throughout the remainder of the year.

Robert G. Underdal, M.D., Chairman

COUNCIL ON REVIEW DEVELOPMENT

The Council on Review and Development met on September 29, 1973 and February 1, 1974. Quorums were present at each meeting.

The Handbook on Committee Guidelines was distributed prior to and discussed at the February meeting. The work was done by Ron Davis, Ed.D., through records research and by direct contact with officers, committees,

missioners, committee chairmen, the Executive Director, Headquarters Staff, and members of committees. The Handbook was approved by the Council on Review and Development.

The Handbook on Committee Guidelines consists of a listing of committees, committee membership, committee charges, and operating methods. The book will prove most helpful to the Society and to the officers, commissioners, and committee chairmen in particular. Two hundred copies will be printed. Complete copies of the book will go to committee chairmen, commissioners, officers, and the Council. Each committee member will have a copy of that portion related to his committee only.

The Council on Review and Development commended highly Dr. Davis of his excellent production, a work that in fact required several years to prepare, and a project that has been discussed for ten years at least. An official letter of commendation was sent to Dr. Davis over the signature of the President and the Committee Chairman. It is our hope that the Committees of the Society will revise the Handbook each year in order to maintain a worthy document. The Committee advised the Executive Director to oversee the various necessary revisions in the future as charges to committees change.

Proper cataloging and filing of the Medical Society papers, documents, meeting reports, historical material, etc., is a problem that the Society must face in the future. The Committee felt that expert advice must be sought on this matter and accordingly a request was made that Mr. Hilliard, Executive Director, and Drs. John Rhodes and Charles Styron arrange a conference with a staff member of the Department of Archives and History to discuss the available materials and the proper way to use them for the benefit of the Society.

The Committee on Archives and History previously requested that the Committee be disbanded. After each discussion and in view of the request such action was recommended in the February meeting of the Council.

The Council received a request that the Committee Auxiliary and AMA-ERF be discontinued. The Council therefore recommended that the Committee on Auxiliary and AMA-ERF be renamed the Committee Advisory to the Auxiliary, and that this Committee be assigned responsibility for the AMA-ERF activities.

The Committee on Health Care Delivery expressed a desire to have as its primary activity in the coming year "accessibility of medical care." The Council approved this request but expressed the opinion that specific activity of committees is the committee prerogative in the absence of specific instructions from the Society.

The Committee Advisory to the Department of Motor Vehicles recommended a name change to the Committee Traffic Safety. This recommendation was approved. The North Carolina Medical Foundation in accordance with its bylaws meets at the first regular meeting of the Executive Council which is held at the Fallclave. Sentiment was expressed that the time allotted for the meeting is insufficient to consider the many problems of the Foundation. It was suggested that the Board of the Foundation consider a regularly scheduled meeting with sufficient time to consider its business.

The Council on Review and Development recommended strongly to the Committee on Personnel and

Headquarters Operation and to the Finance Committee that an additional Headquarters Staff executive be authorized. This has become necessary because of the probability that one staff executive will be assigned full time to legislation and that much time will be required of the Headquarters Staff in PSRO activities.

The Chairman of the Council on Review and Development recommended that any change in objectives or name change of a committee should be formally requested by the Chairman of that Committee to the Council on Review and Development by letter.

The Council on Review and Development next reviewed the entire committee structure of the Society with regard to Commission assignment and Committee name and content. The above recorded actions are in part an outgrowth of this discussion. An additional action was a majority vote to drop the Committee on Medicare and add its function to the duties of the Insurance Industry Committee.

Charles W. Styron, M.D., Chairman

COMMITTEE ON DISASTER AND EMERGENCY MEDICAL CARE

During the spring months committee members met with Mr. Billy Talbert who was then formulating his final draft for The Comprehensive Emergency Medical Services Enabling Act. Three recommendations were made to Mr. Talbert. 1) That at least three physicians be included as members of the council. 2) That physician members be those licensed to practice medicine in North Carolina 3) That the chairman of the E.M.S. Advisory Council be elected by the members of the council in lieu of being appointed by the Secretary of the Department of Human Resources.

With the formation of the State Council during the summer the committee met at Southern Pines Fallclave. Mr. O'Neil Jones an ex State Senator, now Chairman of the Council, Mr. David Warren, the legal counsel and newly employed members of the Division of E.M.S. were in attendance. Although the staff had not been completed, envisioned policies were discussed.

This new division of the Department of Human Resources had been established by a \$750,000 appropriation from The General Assembly.

There was disagreement by the physicians as to the proposed designation of "Trauma Centers" and the tentative proposal of patient placement. Since the division had just been formed any definitive action was postponed with the understanding that the Division of Emergency Medical Services would make a report to the committee every six months so that they could continually monitor the progress of the program.

A motion was made, seconded, and duly passed to the effect that: "The Committee on Disaster and Emergency Medical Care Request the Legislative Committee of The North Carolina Medical Society to use all available means to have the Good Samaritan Law expanded to cover all Emergency Situations.

George A. Watson, M.D., Chairman

COMMITTEE ON DRUG ABUSE

The Committee on Drug Abuse of the North Carolina Medical Society had one regular scheduled meet-

ing at Pinehurst, North Carolina on September 28, 1973. The concerns and activities of the Committee during the past year are reflected in the contents of the minutes. The Committee has maintained communication and collaboration with the North Carolina Drug Authority in the effort to implement the State Plan and to disseminate information about drug abuse to interested parties. Another concern of the Committee has been to see that adequate procedures are available and in use to deal with drug abuse by physicians. Other matters of lesser concern have been the subject of communications by various members of the Committee with those of both inside and outside the Medical Society.

Kenneth E. Rockwell, M.D., Chairman

COMMITTEE ON EYE CARE AND EYE BANK

The Committee on Eye Care and Eye Bank held its regular meetings as in years past.

No unusual happenings other than being able to handle legislation of the optometrists which we felt was detrimental to medicine, in our favor.

Paul M. Abernethy, M.D., Chairman

COMMITTEE ON FINANCE

The Finance Committee met as usual in September, and prepared the budget for 1974, which was approved by the Council, and is in your Delegate's package. In order to balance the budget it proved necessary to take into account certain items which have heretofore been ignored—such as increase in dues from anticipated increase in membership. This means that we are unlikely to have in 1974 a budget surplus comparable to the approximately \$60,000.00 operating surplus which we had for 1973.

We were able in 1973 to put into an operating reserve fund, as the Council instructed us, monies equal to (1) the original cash payment for the airport property, (2) the quarterly payments made on the mortgage for the airport property, (3) the investment income realized from money in the reserve fund, and (4) 5% of the operating budget. Into this fund in addition are to go the excess dues collected from new members who have not paid the extra \$50.00 dues for five years with which we financed the headquarters building. We have not provided in the 1974 budget for the 5% of the operating budget for this reserve fund but the other amounts will be automatically available as they are not taken into account in the budgeted income.

The Society has prepaid the mortgage on the Greenfield property—which is the last purchased piece of the headquarters site and the building and grounds are free and unencumbered. The society is free of debt and our reserve fund at year's end amounted to slightly less than \$93,000.00.

T. Tilghman Herring, M.D., Chairman

COMMITTEE ON HEALTH CARE DELIVERY

The Committee on Health Care Delivery has, since its inception in 1971, had some difficulty defining what its role or mission was to be. Certainly, in the delivery of health care, there are a number of identifiable factors or problems which might concern this committee. Some of these factors might be cited as follows: 1)

Problems of accessibility 2) Problems of quality control 3) Problems of cost containment 4) Problem of health manpower availability 5) Problems of maldistribution 6) Relationship with third party carriers 7) Relationship with present and planned government programs 8) PSRO 9) Health education 10) Preventive care and health maintenance 11) Development of new systems of health delivery 12) Need for primary care providers.

Though all of these factors are justifiable concerns for the Committee on Health Care Delivery, it has been conceded that involvement in all of these areas is too broad, too impractical, and in most instances overlaps with concerns of other standing committees. However, in studying the missions of other committees of the North Carolina Medical Society, it seems obvious that no one committee has been specifically charged with studying the problems of accessibility into the health care system.

At the Fall 1972 conclave of the N. C. Medical Society, the Committee on Health Care Delivery approved the following resolution:—"that the primary mission of the Committee on Health Care Delivery is to concern itself with the problems of health care accessibility." Though not mentioned specifically, it is possible that at some future date this committee may wish to be renamed more in keeping with its primary mission of accessibility.

The committee spent much of its allotted time at the Fall Conclave discussing and studying a questionnaire circulated by the Durham-Orange County Medical Society which polled the licensed physicians of the two county area on the problems of health care accessibility and possible solutions. There was unanimous agreement by the committee that a similar study be undertaken in a broader sense by separately structured questionnaire sent to every licensed physician in North Carolina. However, the feeling was expressed that this should be undertaken after completion of the Durham-Orange County study, in order to best utilize the lessons and trends learned from this information sampling technique.

Accordingly, the following resolution was approved by the committee:—"that we finish out score counting in Durham-Orange and if it looks like a fairly clear cut direction is emerging from that, this Committee on Health Care Delivery will sponsor the design of a questionnaire having to do with problems of accessibility in the system and with the proper staff support from the State Medical Society, this will be sent out to all licensed physicians with a North Carolina address."

The Durham-Orange County project is nearing completion, and the staff of the North Carolina Medical Society has been alerted that we can soon concern ourselves with designing and circulating a state wide physician questionnaire exploring the problems of health care accessibility.

The important point to stress regarding this committee's concerns and activities is that after more than two years trying to identify a specific mission not overlapping concerns of other committees, pursuing the problems and solutions of accessibility into the health care system has emerged as the primary concern of the Committee on Health Care Delivery. The questionnaire technique of information sampling is intended as a

first method of carrying out the mission of this committee.

Patrick D. Kenan, M.D., Chairman

GOVERNOR'S COORDINATING COUNCIL ON AGING

This newly reconstituted committee is being buffeted by variable Federal regulations and directives, an insecure position in the Department of Human Resources, and an uncertainty in the appropriations to be made by the present session of the State Legislature.

Despite this, the Staff of the Governor's Coordinating Council on Aging has been providing technical assistance to prospective projects in the field of both Title III and Title VII of the Older Americans Act of 1965, as amended.

Thirteen new Title III projects consisting of twelve Home Health Service projects (which will be of particular interest to the State Medical Society) and one library project have been approved by the Staff's Technical Review Committee and approval by the Regional Office in Atlanta is expected. These new projects represent a total Federal amount of funding, coupled with local matching funds, to total \$305,008.00. These awards are no longer available for a five year period on a sliding scale but are for a period of one year at which time a full review will be required. Seven continuation projects under Title III have been processed, representing Federal funds and local matching funds of \$239,573.00. Title III programs consist of comprehensive planning, coordination and direct service projects.

The nutritional program under Title VII of the Older Americans Act of 1965 came to a halt when funds were frozen. There has been re-application and grants have been issued as of 31 December 1973 for a total of 4,493 meals per day, five days per week. These programs which are ongoing in scattered regions throughout the State are not totally successful and in at least one instance have been widely resisted, possibly because of lack of information being conveyed to the older citizens, lack of "grass roots" initiation for the program, and probably lack of coordination with other ongoing programs of similar aims. In this area, Federal funds will amount to \$2,050,156.00. Coupled with non Federal matching will amount to \$2,277,951.00.

The total for all projects under Titles III and VII including both Federal and non Federal shares will amount to \$2,822,531.00. The recommendation for distribution of these funds is the responsibility of this committee.

Background information, allocations, and projected budgets concerning the above notations are on file at the Raleigh office of the North Carolina State Medical Society.

The uncertainties of the committee status and future activities has not changed during this interval.

Thomas R. Nichols, M.D., Representative

COMMITTEE ON HOSPITAL & PROFESSIONAL RELATIONS TO N. C. HOSPITAL ASSOCIATION

The Committee held its annual meeting at 2:00 p.m., Thursday, September 27, 1973 in Southern Pines during the Medical Society's Committee Conclave and made

several recommendations to the Executive Council of the State Medical Society. The committee attendance was excellent and a very worthwhile exchange of ideas was conducted. Several resolutions and recommendations were adopted which are detailed in the minutes of that meeting.

The Committee has had only two complaints in the field of Hospital & Professional Relations. One of these involve the question of detailed delineation of privileges thought to be required by the JCHA, raised by the District Memorial Hospital at Andrews, North Carolina. After conferring with the representative of the JCHA and several phone calls to Mr. Mashburn, the administrator, and Dr. Clark, the Chief of Staff of the hospital concerned, it was possible to relieve some of their anxieties. Since I have heard no more from them, I assume that the problem has been resolved satisfactorily.

The Committee would again like to urge the Medical Society to take the initiative in conjunction with the North Carolina Hospital Association to act upon the recommendation made in Paragraph II in our Committee minutes of September 27, 1973. I have had letters and oral communication from several members of the Society saying that they were pleased that this recommendation had been made and looked forward to the development of some better and more efficient means of documenting good medical care. This could be in the form of a workshop with hospital staff physicians, administrators and medical records personnel invited to attend.

J. M. Van Hoy, M.D., Chairman

INSURANCE INDUSTRY COMMITTEE

The Insurance Industry Committee has had a very busy year. We continue to have an increasing number of problems involving retrospective peer review of services; less so of fees. (See the February 1974 issue of the *North Carolina Medical Journal* for further details.)

Bernard A. Wansker, M.D., Chairman

COMMITTEE ON LEGISLATION

The work of your legislative committee continues to expand at an exponential rate. Our society is fortunate to have the effective and dedicated service in the legislative area of our attorney Mr. John Anderson and the staff assistance of Mr. Steve Morrisette.

The bills with importance to medicine considered by The General Assembly and by the U. S. Congress are too numerous even to list by title for this report. Below is a brief summary of the first session of the 1973 Assembly in those areas most directly affecting our membership.

ABORTION (HB 615) The abortion law in North Carolina was rewritten to comply with the U. S. Supreme Court decision.

AMBULANCE ATTENDANT (HB 1079) The ambulance law was amended to require a certified ambulance attendant plus the driver during emergency missions.

APPROPRIATIONS (HB 50) The appropriations bill called for a uniform rate of reimbursement for state programs at the same level as the medicaid program.

CERTIFICATE OF NEED (HB 648) The certificate of need program was repealed following the determination by the N. C. Supreme Court that the law was unconstitutional.

EMERGENCY MEDICAL SERVICES PROGRAM (SB 592) Established comprehensive programs within the Department of Human Resources.

INSURANCE COVERAGE (SB 669) Insurance coverage for newborn infants from the moment of birth.

INSURANCE COVERAGE (HB 743) Allows companies to make payments for disabilities upon certification of chiropractors.

INSURANCE COVERAGE (HB 744) The bill adds "a duly licensed chiropractor" within the definition of "medical service plan."

MENTAL HEALTH (HB 373) This act amended Chapter 122 of the General Statutes relating to the rights of patients at treatment facilities for the mentally ill and retarded.

MENTAL HEALTH There were 16 bills in all in this group, each making significant changes in our mental health laws.

NURSES EXPANDED ROLE (HB 168, HB 169) The Boards of Nursing and Medical Examiners to work together in developing rules and regulations governing the performance of medical acts by registered nurses.

OCCUPATIONAL AND SAFETY HEALTH (SB 342) Act provides for the state to take over the occupational and safety health program in North Carolina.

OPTOMETRY BOARD OF EXAMINERS (SB 844) Revised the General Statutes relating to the powers and duties of N. C. State Board of Examiners in Optometry.

PHYSICIAN SHORTAGE (HB 512) Appropriated \$100,000 for incentive payments to doctors who will practice in medically deprived areas.

(HB 1123) Established a \$7.5 million reserve fund for an additional degree granting school of medicine.

(HB 1237) Appropriated \$456,000 for the "Governor's Rural Health Program."

PUBLIC HEALTH Eight bills having to do with changes in the laws affecting public health departments were made law.

STATE GOVERNMENT REORGANIZATION The Department of Human Resources was extensively reorganized.

NATIONAL LEGISLATION The N. C. Medical Society is indeed fortunate to have Ed Beddingfield serving on the AMPAC Board and the AMA Legislative Council. Space will not permit a national legislative review. The membership is referred to the AMA News where excellent accounts of this legislation is presented weekly. It is fair to say that the Congress and the American people now seem ready to establish a national health insurance program. Our job as physicians is to get out and help get elected to Congress men and women who have the kind of judgment required to develop a health care system that preserves the great strengths of our present system, and protects our patients from a massive unfeeling, inefficient bureaucracy.

H. David Bruton, M.D., Chairman

COMMITTEE ON MARRIAGE COUNSELING AND FAMILY LIFE EDUCATION

The Committee on Marriage Counseling and Family Life Education met on Thursday, September 27, 1973, in the sunroom at Midpines Club, Southern Pines, N. C. from 2:00 to 5:00 p.m. The first item on the agenda was a program for the annual meeting in May. This program had been proposed for the meeting last year but was not put on because of a problem of securing a room. It was suggested that a similar program of this nature be planned for the annual meeting in 1974. The following recommendation was made, seconded, and passed. It was recommended that this committee plan on a two hour program on sex education at the annual meeting in May, open to the members of the State Society, wives, and guests, which may be addressed by some of the common marital sexual difficulties a physician sees in daily practice with allotted time at the end of the program for possible anonymous questions from the people screened and selected at random for better representation. Dr. John Reckless agreed to chair this program. It was suggested that Dr. Robert Brame, Chairman of the Section of Obstetrics and Gynecology, be contacted to see if possibly this could be worked into his program and also, it was suggested that the possibility of the Women's Auxiliary could be contacted for some help on implementing this program. A letter to Dr. Robert Brame, Chairman of the Section of Obstetrics and Gynecology Committee, has been written, but to date, we have not received an answer.

The second item on the agenda was a resolution honoring Dr. Ethel Nash who died earlier this year. Dr. Reckless made the following motion which was duly seconded and passed to the effect that "be it resolved that the North Carolina Medical Society and its Committee on Marriage Counseling and Family Life Education record with deep and sincere regret the untimely death of Mrs. Ethel Nash early in 1973. Mrs. Nash, through her pioneer work with sex education, brought to North Carolina and its universities a wealth of knowledge and vision from which sprang a number of educational and treatment facilities. Her death represents a loss to her family, her patients, and her many friends and colleagues in medical and allied professions in the field of marital and sex counseling."

On the Budget request for 1973 which allocated three hundred dollars, a letter was written to increase that budget from three hundred to one thousand dollars.

From the informal conversations with many of the members of the committee, there appeared to be somewhat of a blasé attitude and ineffectualness of the impact of this committee, in particular on the whole State Medical Society in general. It would seem that the Medical Society has never taken any action on supporting the law to give contraception to minors, nor have they made any effort in recent months to support the Supreme Court's decision on January 22, 1973, for legalizing abortion. However, every effort will be continued to be made, to begin infusing the Medical Society with information on human sexuality, sex counseling, marriage counseling, abortion counseling, and contraceptive counseling. A letter to Dr. Rachel Davis has been submitted concerning her part to try to get the Ladies Auxiliary to sponsor an evening or breakfast session on human sexuality.

Although I keep hearing time and time again from

physicians across the state that something needs to be done in the areas of sex education, family life education, abortion counseling, contraceptive counseling. I see little enthusiasm and support in terms of financial, political, educational to meet the needs of the requests from our physicians.

Takey Crist, M.D., Chairman

COMMITTEE ON MATERNAL HEALTH

The Maternal Health Committee does not have a complete report on maternal deaths for the year 1973 as of the date of this report. There has been a change in the recovery system of data on maternal deaths from the State Board of Health and they are obtainable only on a quarterly basis. This report includes maternal deaths through October 31, 1973. There was a total of 33 maternal deaths. Twenty-one of these deaths were remote or non-obstetrical deaths, three were due to hemorrhage, two to infection, four to toxemia, two to embolism, and one to cardiac failure.

The last three years have shown a steady decline in maternal deaths, which indicates that the continued strong interest in maternal and child health in our state is beginning to show favorable results. The maternal death workload for the Chairman has decreased. However, as the Society gets more involved in social medicine, the Committee seems to have more and more inquiries locally and abroad in the country for input to planning and programming of maternal and infant projects.

Much time has been spent during the last year by the chairman and other interested members of the Committee in pursuing the work of the Governor's Task Force for the Development of Regionalization of Maternal and Infant Care. A very significant document has emanated from this work and is now in the hands of the State Legislature, having been voted out of the Finance Committee. The Executive Council of the State Medical Society has endorsed this project.

The Chairman wishes to express his appreciation for cooperation and continued support of the Executive Council of the State Medical Society. Listed below is a breakdown of the expenditure of the \$600 allowance from the State Medical Society which is used to defray secretarial, mailing and publishing expenses incurred in the course of conducting the work of the Committee on Maternal Health by the Chairman:

January 1, 1973-December 31, 1973

Expenditures

Secretary's salary (\$41.66 2/3 per month).....	\$500.00
Telephone	16.70
Postage	25.30
Duplicating charges	8.00
Office supplies	50.00
Total	\$600.00

W. Joseph May, M.D., Chairman

MEDIATION COMMITTEE

The Mediation Committee has met periodically during the year to consider cases referred to it by the North Carolina Medical Society. In view of the number of

patients treated by North Carolina physicians every day, the number of problems which have been brought to the attention of this Committee has been small. The Committee continues to be an effective mechanism for resolving problems between North Carolina physicians and their patients. Those problems involving primarily the matter of fees and third party reimbursements have been referred to appropriate committees of the Society.

In the remainder of the cases, certain patterns have been noted. First, the Committee has considered several instances in which problems arose in the Emergency Room setting, particularly with non-resident and transient patients injured in accidents. It was very important that in such cases the physicians rendering service in Emergency Rooms pay particular attention to attitude, thoroughness, and consideration for the wishes of the family and the patient, remembering the increased stress of being injured when away from one's home.

Second were problems which apparently developed as a result of inadequate or faulty communication between the doctor and the patient, and between the doctor and the patient's family, especially in the case of severe and potentially fatal diseases or injuries.

The third problem area which emerged was the matter of billing procedures, and in particular, problems created by requiring that a patient's bill be paid before an insurance form was completed. The Committee has succeeded in modifying these procedures in some instances so that they are more satisfactory to the patient.

The Committee format and size appear to be quite satisfactory in terms of achieving the Committee's proper objectives.

David G. Welton, M.D., Chairman
John Glasson, M.D., Secretary

COMMITTEE ON THE MEDICAL ASPECTS OF SPORTS

Two committee meetings were held during 1973. The first was on July 4 in Wrightsville Beach, North Carolina. Members present were Wilson, Bassett, Bowman, Boyd, Clippinger, DeWalt, Jennette, Reibel, Taft, Rhodes, Proctor, Mainer, and Sauls (guest). Absent were Dineen, Hiller, James, Montgomery, Wrenn, and Harris. The main agenda item was a presentation by Mr. Al Proctor, Coordinator for the Sports Medicine Program in the Department of Public Instruction who presented a report on the activities presently underway in his program. The major thrust of his section presently is to develop a system of teacher-athletic trainers to serve the high schools of the state to help with prevention, treatment, and rehabilitation of sports injuries in public schools. Ways in which the Committee on the Medical Aspects of Sports and the Department of Public Instruction might better coordinate their activities were discussed. Continued liaison between these groups is planned for the future. The Committee also considered legislation passed by the House of Delegates of the North Carolina Medical Society at its annual meeting in May, 1973 relative to condition of public school athletes. It was recommended that the issues raised receive further consideration by the Advisory Committee on Sports Medicine in the Department of Public Instruction before being implemented. The Committee also approved a recommendation to request the President of the North Carolina Medical Society to communicate

with each County Medical Society President requesting that they designate or appoint a committee of physicians to be responsible for the medical aspects of sports in the county area. Such a letter was subsequently written by Dr. Gilbert, the Society President.

The second meeting of the Committee was held October 12, also in Wrightsville Beach. The final draft of the Athletic Participation Form was approved and it was recommended that this form be forwarded to Dr. Gilbert who should direct it to the Chairman of the State Board of Education requesting that completion of this form prior to participation in organized athletics be a requirement in each system as opposed to being on a voluntary basis. Such a recommendation was written by President Gilbert to Dr. Craig Phillips on December 10, 1973. As yet the result of this correspondence are unknown.

I believe our State is in the forefront in the planning and development of programs to prevent and treat injury to public school athletes. I appreciate very much the opportunity to be part of this commitment.

Frank C. Wilson, M.D., Chairman

COMMITTEE ON MEDICAL EDUCATION

In 1973 the House of Delegates approved a resolution calling for documented participation in continuing education as a requirement for continued membership in the North Carolina Medical Society. This committee was charged with implementation and administration of this proposed program.

Considerable discussion has taken place regarding compulsory continuing education. To have a strong program will require a minimum budget of \$40,000 per year. This estimate is based in large part on budgets obtained from states which already have continuing education programs in operation.

Several tentative programs are under consideration. However it seems clear that further planning on the part of this committee will be dictated by the extent of the financial commitment the society is prepared to make.

Richard H. Ames, M.D., Chairman

MEDICAL-LEGAL COMMITTEE

Review of work done to date.

A joint meeting of the Medical-Legal Committee of the North Carolina Medical Society and the Medical-Legal Committee of the North Carolina Bar Association was held on April 29, 1973 in Pinehurst, North Carolina. Discussion covered areas of court appearance on the part of physicians, fees for expert medical testimony, suits involving professional liability and health care in penal institutions. The Bar group signified their intention to ask their parent group to consider the matter of fees.

In regard to malpractice it was pointed out that informed consent is becoming increasingly important.

It was the consensus of the joint committee that a further survey of health care in jails in North Carolina should be conducted. This has already been initiated.

A meeting of the committee was held on September 26, 1973, at Midpines. The matter of certain attorneys asking the committee members to review malpractice claims was discussed at length and it was the feel-

ing of the committee that the Medical-Legal Committee should not provide review assistance in malpractice cases but should encourage the attorney to obtain professional review on his own.

The report of the Presidential Commission on Malpractice was noted and it was the consensus that very little of a constructive nature could be expected from its review.

The Chairman attended a meeting of the American College of Legal Medicine in Cleveland, Ohio, on September 9, 1973, and a critique of the report of the Presidential Commission on Malpractice was given.

Joint meetings were held in approximately 24 counties.

The committee is now in the process of contacting authorities in all the counties of North Carolina in regard to health care in their jails.

No instance of alleged unethical action on the part of physicians has been reported to this committee.

Julius A. Howell, M.D., Chairman

COMMITTEE ON MEDICARE

The Committee held one meeting on September 7, 1973 with nine out of twelve members present. Guests of the Committee included representatives from the Medicare Division of the Prudential Insurance Company of America and the Department of Social Services. Clarification was sought by the Committee as to the status of payment of physicians for concurrent care rendered the same patient. The representative of the Prudential Insurance Company of America reported that his company after investigation felt that there were some 40 cases per week receiving medically unnecessary concurrent care. This figures out to be less than .02 per cent of claims handled. He further estimated that half of these cases of medically unnecessary concurrent care are patient induced rather than doctor induced.

Since the meeting only one physician complaint has been directed to the Medicare Committee. This has been handled to the physician's satisfaction.

William T. Raby, M.D., Chairman

COMMITTEE ON MEDICINE & RELIGION

(Report not received April 10, 1974)

COMMITTEE ON MENTAL HEALTH

The year 1973 has been a very busy one for the Mental Health Committee. We have all been deeply concerned with the problems surrounding the commitment procedures and at the time of this writing the proposed acts are being considered by the Legislature. These acts may very well not prove to be perfect but it is the opinion of the chairman that they represent a tremendous amount of work on the part of the committee and that they also represent a very considerable improvement in the commitment procedures. The Committee has been deeply concerned by what seems to be the constitutional issue in that we are unable to find ways to commit patients who perhaps need to be committed and who would benefit from commitment in the sense that they could then be forced to take medication which would be of great help to them.

would reduce their symptomatology considerably. A patient under the new laws cannot be committed if he is merely suffering from a mental illness and is not a danger to himself or to others. The chronic schizophrenic who would benefit from medication which we now have available could not be committed as we understand the law. This in reality perhaps represents a conflict between the rights of an individual as an individual and his rights to treatment. As physicians we have been deeply concerned with his rights as a patient but we also recognize that we must live within the confines of the constitution.

The Committee has also been concerned and engaged in the AMA-Southeast Regional Mental Health Conference to be held in Atlanta on April 5-6, 1974. The title of it is "Public and Private Mental Health Care: Quo Vadis" chosen at a meeting held in Raleigh in September of representatives of seven (7) southeastern state medical societies. Dr. E. William Busse, Duke University Medical Center where he is Chairman of the Department of Psychiatry will be one of the main speakers. An effort is being made to encourage residents of North Carolina to attend this meeting.

There has also been an effort established to bring about a closer cooperation between the Medical Society's Mental Health Committee and the North Carolina Neuropsychiatric Association which is also the North Carolina District Branch of the American Psychiatric Association. Tentative plans were made for the chairman of the North Carolina Medical Society Mental Health Committee to meet with the Executive Council of the Psychiatric Association and it is also hoped that we can arrange for the President and the President-Elect of the Psychiatric Society to serve on the Mental Health Committee.

It has been a busy and we hope a productive year.
Philip G. Nelson, M.D., Chairman

SUBCOMMITTEE ON ALCOHOLISM

The Subcommittee on Alcoholism met at the North Carolina Medical Society Headquarters Building on December 16, 1973. The disadvantages of the existing commitment laws were noted, and it was considered that especially in the case of alcohol related problems, it is unfortunate that family members are unable to initiate the commitment procedure so that in effect both the alcoholic and those persons close to him are denied access to treatment programs. It has been the experience generally as well as elsewhere that enforced treatment of the alcoholic may in fact often have a very favorable outcome and patients often express their gratitude at a later date that those around them were concerned enough to take the necessary steps on his behalf. There seems to be a general lack of awareness on the part of those responsible for this type of legislation that commitment to an out-patient treatment facility can lead to equally favorable results as those obtained in in-patient setting.

Concern was expressed about the lack of adequate medical involvement in planned detoxification programs for alcoholics, where emphasis is being placed on a so-called social model. It is clear that when dealing with problems of alcoholism, social, vocational, physical, emotional factors must be taken into account in the rehabilitation process, and to ignore the medical

aspects of alcoholism is again to deny patients adequate treatment. The Committee passed a resolution that adequate medical back-up should be available in any detoxification program for alcoholics.

D. E. Macdonald, M.D., Chairman

SUBCOMMITTEE ON MENTAL RETARDATION & CHILDREN SERVICES

(Report not received April 10, 1974)

COMMITTEE ON MEMORIAL SERVICES

The memorial services for deceased physicians will be combined with a Prayer Breakfast, Monday morning, May 20, 1974, in the Crystal Room, Pinehurst Hotel, Pinehurst.

W. Otis Duck, M.D., Chairman

COMMITTEE ON NOMINATIONS

Report of the Committee on Nominations will be given in the HOUSE OF DELEGATES, opening session, Sunday, May 19, 1974, Cardinal Ballroom, Pinehurst Hotel, Pinehurst.

J. Elliott Dixon, M.D., Chairman

ADVISORS TO NORTH CAROLINA ASSOCIATION OF MEDICAL ASSISTANTS

This has been an unusual year inasmuch as three persons have served as President.

This Association's House of Delegates voted in November 1972 to institute the annual year that most states found best to their organization, namely April to April. The annual National meeting is in October each year and this means changes and information disseminated from AAMA can be passed on to states at the April meeting rather than a state meeting in November. This meant that the President who was elected in November 1972 was to serve 18 months and her successor's term would begin April 1974. Mrs. Ottilie Kirby served from November 1972 to July 1973, when she left the medical profession and the Presidency was assumed by Mrs. Barbara Godwin of Fayetteville. On January 7, 1974, Mrs. Godwin resigned by mail due to family reasons and Mrs. Ruby Guigou of Morganton was elevated to the presidency.

Mrs. Guigou had the winter Board meeting in Winston-Salem in January.

Total county chapters in the State now is 18, an increase of 7 in 18 months. Contacts at the North Carolina Medical Society annual meeting in Pinehurst in May 1973 netted several new chapters.

The annual state educational workshop was held in the North Carolina Medical Society building in Raleigh on Saturday, September 15, 1973. One half day was spent with Professional Management representatives and one half day was spent with a Credit & Collections firm—one of the best workshops in recent years.

Ten of the State members attended the 17th Annual meeting of the American Association of Medical Assistants held in Washington, D. C. October 21-27, 1973. This was the first international convention with medical assistants from London, Scotland, Ireland and Canada.

The Annual State Convention will be held at the Hilton Inn, Winston-Salem, North Carolina, April 26-28,

1974. The theme of the Convention is: IT'S WHO'S OUT FRONT THAT COUNTS!

The membership committee is actively engaged in entering counties where no organization exists and any help from the Medical Society members would certainly be appreciated by this organization.

Advisors:

Emmett S. Lupton, M.D., Greensboro
William H. Shaia, M.D., Charlotte

COMMITTEE TO WORK WITH THE NORTH CAROLINA INDUSTRIAL COMMISSION

The Committee has had an active year. New members to the Committee this year are Doctors Leonard Goldner of Durham and Robert Miller of Charlotte. Doctor John W. Morris, Medical Director as well as the entire staff of the North Carolina Industrial Commission have been most helpful in cooperating with our Committee members. Doctor Morris and Mr. Forrest H. Shuford II of the Commission staff attended the Spring Meeting of the Committee at Pinehurst.

The new fee guide was received by most of our members in the late spring and most comments in regards to this schedule have been favorable. The Committee has informed the Commission that it will work with them so that a new fee guide will be published on an every two year basis. The members of our Society are again urged to document any charge in excess of the maximal allowable charge provided by the fee schedule, by a detailed description of the extraordinary service rendered so that the Commission and your Committee will be able to more fairly ascertain a reasonable fee.

Ernest B. Spangler, M.D., Chairman

COMMITTEE ADVISORY TO N. C. DEPT. OF MOTOR VEHICLES

(Report not received April 10, 1974)

COMMITTEE LIAISON TO NORTH CAROLINA PHARMACEUTICAL ASSOCIATION

During the year I have attended several joint meetings with members of the Medical Society and with members of the Pharmaceutical Association in regard to prescription refills and drug labeling bills. The first meeting was held on Tuesday, September 11, 1973 in Southern Pines with Dr. David Bruton and representative members of the Pharmaceutical Association concerning the drug labeling bill, which was House Bill No. 156.

On September 27, 1973 the Committee Liaison to the North Carolina Pharmaceutical Association held its meeting at the regular Committee Conclave. Highlights of this meeting were:

- I. Mr. Clarence B. Ridout of the North Carolina Department of Social Services reviewed all the doctors dispensing under Medicaid. The following physicians were approved for dispensing drugs under Medicaid: Physicians in: Moyoek, Hatteras, Gatesville, Sunbury, Englehard, Jackson and Richlands.
- II. Mr. Frank Yarborough, Paid Prescriptions, Inc., gave a Report to the Committee, stating that Paid

Prescriptions was employed by the Department of Social Services to administer the Medical program for prescriptions in North Carolina. Under this program, drug utilization is computed for Medicaid patients and then submitted to four district Peer Review Committees of physicians and pharmacists. The Committee reviews exceptions identified by parameters developed by these committees. These committees have met twice to date and reviewed 896 questionable drug prescription practices. After the reviews completed, the Committee will send out a letter to the pharmacists or physician dealing with one of three general areas. They are: uneconomical continuous refills; apparent over utilization; and patient using multiple providers of drugs. The Committee Liaison to the North Carolina Pharmaceutical Association has reviewed the report of Paid Prescriptions and feels it is a worthwhile service. The Committee has requested that Mr. Yarborough prepare a report on the operations of Paid Prescriptions and make it available to the North Carolina Medical Journal. Mr. Yarborough also pointed out that there has been a savings in the 585 prescriptions reviewed of \$91,495.46 over a year's period.

- III. The Committee discussed a variety of problems associated with prescribing practices in North Carolina. A problem that has caused some concern in recent months is the practice of the pharmacists calling a physician's office to ask permission to give a refill to a patient and having the nurse or secretary give him the okay. The pharmacist is put in the position of not knowing positively if the physician has, in fact, given permission to refill that drug. Also a short discussion concerning the problems of nurse practitioners dispensing drugs in rural clinics was discussed. It was the consensus of the Committee that a subcommittee should be appointed by the Chairman with representatives from the North Carolina Pharmaceutical Association and the Medical Society to prepare an update of the N. C. Physician-Pharmacist Code of Understanding.

- IV. There was also a discussion of House Bill 156 which concerns the labeling of prescription drugs. The bill requires that a prescription be labeled unless otherwise specified by the physician. The Pharmacy Association has found some difficulty in supporting the bill because they feel that it will increase drug abuse. The members of the Committee felt very strongly that House Bill 156 should be supported and that it was a good bill. Mr. John Anderson pointed out that the bill could be amended so that the penalty for violation of the Act would be determined by the N. C. Board of Pharmacy.

On October 25, 1973, Dr. George Gilbert, President of the North Carolina Medical Society, Dr. H. David Bruton and I met with the North Carolina Pharmaceutical Association with regards to prescription refills. This meeting was held at the Institute of Pharmacy in Chapel Hill. As a result of this meeting, it was decided that the Pharmaceutical Association submit

each physician in North Carolina information form as to prescription instructions.

I have also received as chairman of this committee a great deal of correspondence and information pertaining to drug problems in North Carolina.

Charles W. Byrd, M.D., Chairman

COMMITTEE ON OCCUPATIONAL AND ENVIRONMENTAL HEALTH

The Committee met on September 28, 1973 at Southern Pines, N. C. At that time, Dr. Harold Imbus took over as chairman of the committee succeeding Dr. John Brockman who had served for many years as chairman. A vote of thanks was given to Dr. Brockman for his long and very fine service.

Mr. John Lumsden of the Division of Health Services, Occupational Health Branch, State of N. C. spoke to the committee about the current status problem and needs in occupational health in the State of N. C. He outlined the role of his division in conducting occupational health surveys in plants at the request of the Occupational Safety and Health Act function of the State Department of Labor. He also outlined that his division provides many services to industry in occupational health.

The Committee discussed its future role in occupational and environmental health in the State of N. C. The group recommended the following three major functions for the Committee:

1. That we endorse strongly and support the development of speakers and assistance to the local County Medical Society toward educational information on occupational health.
2. Support similar programs on occupational health at the annual meeting at the State Medical Society when it can be accomplished.
3. The Committee urges the State Medical Society to endorse occupational health information to be disseminated in the curriculum of the medical schools in the State of N. C.

Accordingly, a subcommittee to develop the occupational health speakers bureau was appointed. It consisted of Dr. Mario Battigelli as Chairman, Dr. James N. Odson, Dr. Emil Beyer, and Dr. John Brockman. Dr. Bernard Greenberg from the UNC School of Public Health indicated a willingness to assist in the development of educational programs for physicians.

A subcommittee on environmental health was appointed consisting of Dr. Carl Shy and Dr. Emil Beyer.

Prior to and subsequent to the meeting the Chairman contacted the program committee asking for consideration of time to present several occupational health projects at the annual meeting in May. This was denied, it has been several times in previous years. This has been a great concern in that there does appear to be a lack of official interest in providing information to physicians in occupational health. This is of even more concern in view of the fact that physicians are increasingly being called upon to service occupational health needs in communities for employers and employees. Without adequate participation and interest on the part of physicians, the vital decisions so critical to the health needs of a large percentage of our population are being made outside of the medical profession.

We hope to have the speakers and environmental subcommittee active and ready to report to the Fall meeting of the Committee.

Harold R. Imbus, M.D., Chairman

COMMITTEE ON PEER REVIEW

The activities of the Committee on Peer Review have been covered in the minutes of the Council meeting in September. The full Peer Review Committee met at the Committee Conclave in September at which time joint meeting with the Committee on Social Services and consultants from the Social Services Department of North Carolina was held regarding two particular problems.

The principal other activities have been for the most part directed to the North Carolina Medical Peer Review Foundation and no further meetings of the committee have been held.

M. Frank Sohmer, M.D., Chairman

COMMITTEE ON PERSONNEL & HEADQUARTERS OPERATION

Parking lot repairs have been accomplished. Mileage reimbursement has been increased from 10 cents to 15 cents per mile. Hospitalization insurance for the NCMS headquarters staff has been increased from half to full single unit coverage. Authorization has been obtained for the addition of a file clerk. The Medical Peer Review Foundation has leased space on the top floor of our building. Mr. Dan Mainer has been offered the job of executive director of that organization. Maximum accumulation of sick leave for employees has been extended from 30 to 90 days. Vacation for employees has been somewhat liberalized.

A. Hewitt Rose, Jr., M.D., Chairman

COMMITTEE ON PHYSICAL & VOCATIONAL REHABILITATION

(Report not received April 10, 1974)

COMMITTEE OF PHYSICIANS ON NURSING

The committee of Physicians on Nursing met at the Holiday Inn, Burlington, N. C. on March 1, 1973. The committee reviewed proposed rules and regulations that would be used as guidelines by the Board of Medical Examiners to approve nurses in the expanded role. The following motion was passed: ANY RULES AND REGULATIONS ADOPTED BY THE BOARD OF MEDICAL EXAMINERS FOR THE PURPOSE OF REGULATING THE EXPANDED ROLE OF THE NURSE SHOULD INCORPORATE WORDING SIMILAR TO THE RULES AND REGULATIONS PERTAINING TO PHYSICIAN'S ASSISTANTS.

A request by the North Carolina Nurse Anesthetist Association that the North Carolina Medical Society support a bill stating qualifications for a nurse to administer anesthetics was deferred due to lack of information.

Following much discussion the following motion was made: PHYSICIAN'S ASSISTANTS LICENSED BY THE BOARD OF MEDICAL EXAMINERS UNDER

EXEMPTION 13 WOULD BE EXTENDED AN INVITATION TO ATTEND THE MEDICAL SOCIETY'S ANNUAL MEETING AND BE GIVEN A SPECIAL COLOR GUEST BADGE. No further action regarding associate membership in the Society will be taken pending development of paramedical associations.

Mrs. Mary Piner of Onslow County was selected Nurse of the Year and was appropriately honored at the annual meeting of the Society at Pinehurst in May.

The committee met at Pinehurst, N. C. on September 29, 1973. The implementation of the legislation calling for an expanded role of the nurse by the Board of Medical Examiners and the Board of Nursing was discussed. The following motion was passed: IT IS THE SENSE OF THIS COMMITTEE THAT EACH EX-TENDER OF HEALTH CARE OF EACH APPLICANT UNDER EXEMPTION 14 BE CONSIDERED INDIVIDUALLY AND BE RE-REGISTERED PERIODICALLY.

The ongoing activities of the Joint Practice Committee of Medicine and Nursing were discussed. The following recommendation was made: THE COMMITTEE RECOGNIZES THAT ANY CARE RENDERED BY PROVIDERS OF ALLIED HEALTH SERVICES

BE RENDERED UNDER THE DIRECT AND RESPONSIBLE SUPERVISION OF THE PHYSICIAN, AND THAT ANY OTHER SYSTEM PROPOSED IS CONSIDERED TO BE EXPERIMENTAL AND SUBJECT TO REVIEW AND EVALUATION.

Upon further discussion and consideration the following resolution was passed: THE COMMITTEE HAS CONSIDERED THE CONCEPT OF INDEPENDENT FEE-FOR-SERVICE FOR CARE RENDERED BY PHYSICIANS ASSISTANTS, NURSE NURSE PRACTITIONERS AND ASSISTANTS. SIMILAR INDIVIDUALS AND REJECTS THIS CONCEPT AS INVALIDATING PHYSICIAN RESPONSIBILITY FOR MEDICAL CARE.

Consideration was given to changing the name of the Committee of Physicians on Nursing. COMMITTEE ON ALLIED HEALTH PROFESSIONALS was accepted, and was to be recommended to The Council. Guidelines for the Committee were then approved.

Upon motion duly made and passed, the Nurse of the Year Award was discontinued for the coming year.

A new educational T.V. film "Train Your Own Assistant" was reviewed. The committee recommended its distribution to interested parties.

W. Benson McCutcheon, Jr., M.D., Chairman

CONSULTANT ON PODIATRY

As the Medical Society Consultant on Podiatry, I have not been approached by any problems relative to this subject nor have I been aware of any new business being brought to my attention on this matter during the past year of 1973.

Donald B. Reibel, M.D., Consultant on Podiatry

COMMITTEE ON PROFESSIONAL INSURANCE

The Professional Insurance Committee of the North Carolina Medical Society meets quarterly to consider inquiries concerning all types of professional insurance for physicians. The majority of the committee's time is spent in reviewing malpractice claims. The committee

enjoys an excellent working relationship with the Society approved professional liability insurance carrier—a major factor in the North Carolina Medical Society members experiencing the second lowest malpractice insurance rate in the country.

John C. Burwell, M.D., Chairman

COMMITTEE ON GENERAL SESSIONS PROGRAM

The General Sessions Committee proposed a reorganization of the General Sessions Program based on the following considerations.

1. Professional excellence through continuing education is a priority concern of organized medicine at all levels. It was the consensus of this committee that the North Carolina Medical Society should upgrade its scientific program and thereby play some part in the continuing education of primary care physicians in this state.
2. Our three excellent medical schools should become more active in North Carolina Medical Society affairs and should particularly share the society's responsibility for continuing education.
3. An upgraded scientific program would improve attendance to the state meeting and hopefully thereby stimulate general interest of members in the affairs of our medical society.

The reorganized format of the General Sessions will therefore be planned as follows:

Monday—9 a.m.-12:30 p.m.—Scientific Surgical Program presented by the University of Chapel Hill Medical School.

Tuesday—9 a.m.-12:30 p.m.—Scientific Medical Program presented by Bowman Gray Medical School.

Wednesday—9 a.m.-12 p.m.—Socio Economic Program. Conjoint session with Department of Public Health. Address by Dr. Russell Roth, President American Medical Association. Address by Incoming President of the North Carolina Medical Society. Informal talk by Dr. Edward R. Annis.

A special seminar entitled, "Sex after Supper" will be presented at 9:30, Monday evening sponsored by the Committee on Marriage Counselling and Family Life Education.

Kenneth E. Cosgrove, M.D., Chairman

COMMITTEE ON PUBLIC RELATIONS

The Committee on Public Relations met at the M Pines Club in Southern Pines on September 27, 1973, and planned the year's activities as listed below.

1. Continue the PUBLIC RELATIONS BULLETIN with periodic review of its format, content and presentation to maintain relevance and readability.
2. Continued the exhibit at the 1973 N. C. State Fair.
3. Continued the High School Science Fair project for the winner to receive a \$50 award at the 1973 Fair and a certificate at a meeting of the local county medical society.
4. Performed periodic review evaluation of the "INFORMATION PACKET FOR PHYSICIAN" for distribution to new members.
5. Continued the project to give an award to

winner of the N. C. Rescue Squad First Aid competition, presented by a member of the Committee.

6. Conducted an AMA Leadership Seminar under the direction of Marshal Redding, M.D., for development of current and future leaders of the Society.
7. Provided followup on the recommendations of the Conference on Access to Health Care. All agencies involved in the recommendations were contacted with appropriate secondary followup to manifest our intent and concern. To enhance physician productivity a TV tape on "Train Your Own Assistant" was prepared by the committee with supportive questionnaires.
8. Conducted a Conference for Medical Leadership on February 1-2, 1974, on the topic of "Practicing Physician Pressure Points." The first of such meetings held at the Headquarters Office Building with 115 physicians in attendance. Chiefs of Medical Staffs of Hospitals, youthful physicians with leadership potential, plus Auxiliary, committee chairmen and county medical society officers were invited. The Conference was well received in Raleigh according to the evaluation reports completed by those in attendance.
9. Continued the previous policy of distributing *Today's Health* magazine to the Governor, Supreme and Superior Court Judges and members of the N. C. General Assembly while considering the feasibility of changing to *American Medical News* at a later date. A decision will be made at the Committee's next meeting.
10. Sponsored planning for an AMA Practice Management Workshop for physicians soon to go into practice scheduled to be held in February but cancelled because of transportation problems associated with the energy crisis.
11. Began preparation of a brochure in "How to Be a Good Doctor's Good Patient" with Dr. Elizabeth Kanof editor.
12. Prepared for distribution Joint Statement of Policy on Donation of Human Tissue for Transplantation approved by the North Carolina Medical Society and the N. C. Hospital Association.
13. Planned on followup meeting of the Public Relations Committee in March or April to undertake with the assistance of an AMA Consultant on indepth evaluation of the existing external public relations program of the North Carolina Medical Society and to prepare recommendations as to how the North Carolina Medical Society can communicate more effectively with the public.

Appreciation is expressed to the members of the Committee, President George Gilbert, Mr. William Hilliard, Dan Mainer, Mrs. LaRue King, Mr. Gene Sauls, Steve Morrisette, and Mrs. Jackie Cutrell and other members of the Headquarters Staff for the help given in the performance of the activity of the Public Relations Committee. The Chairman is indebted to those folks for the program of this Committee.

John L. McCain, M.D., Chairman

COMMITTEE ON RADIATION

All physicians, whether they are radiologists, urologists, orthopaedists or general or family practitioners must keep permanent records of total body irradiation that we or our employees receive. These records must be passed on to other employers and in turn we shall receive total body irradiation records from previous employees. These rules are set down by federal law.

W. C. Sternberg, M.D., Chairman

NORTH CAROLINA REGIONAL MEDICAL PROGRAM

The year 1973 has indeed been an eventful one for the North Carolina Regional Medical Program. Although President Nixon requested no funds for the Regional Medical Program for the period July 1, 1973 through June 30, 1974, we decided to prepare an application for future activities in hopes that the legislation would be extended. During the first three months of 1973, in spite of the fact that our Program had been directed to phase out by July 1, 1973, as were all other Regional Medical Programs, projects were solicited, obtained and carefully reviewed by the Regional Advisory Group. In March 1973 an application was approved for submission to RMP offices, and this was done. Because of the uncertainty of the future of the Program, many of our key staff personnel resigned and accepted positions elsewhere. However, a dedicated group remained, and we pursued our activities in spite of the gloomy outlook. In June 1973, several weeks prior to the termination of the RMP legislation, Congress approved, and President Nixon signed, a bill extending the RMP legislation for one year. Funding was to be on the basis of a continuing resolution, i.e., to continue at the same level as the previous year.

Although our Program application for 1973-74 was approved, the first three months of the fiscal year (beginning July 1, 1973) were difficult ones because no funds for activities were released. We were able to support our Program Staff on the basis of carry-over funds from the previous year due to the termination of some projects on July 1, 1973. Finally, in the latter part of September we were notified of our funding level for the period for the first six months of the fiscal year. This level was roughly one-half of what we were supposed to receive. In spite of these difficulties we were able to implement the projects that had been submitted in our application of February 1973, emphasis being placed on hypertension, emergency medical services, kidney disease, quality of care and health manpower. In November 1973 we submitted another application for the period January 1, 1974 through July 1, 1974. This was approved at the funding level granted us. In December 1973 President Nixon signed the FY1974 HEW Appropriations Bill that had been passed by Congress. This meant that \$36 million more was due to the Regional Medical Programs for this year, but as of January 1 these funds had not been released. Likewise, funds in the amount of \$89 million plus that had been impounded from FY1973 RMP funds, although ordered released by President Nixon, still remain impounded.

In summary, this past year has been a difficult one because of the uncertainty concerning legislature and

funding at the National level. During this period of time the North Carolina Medical Society has supported us at all times. Our Regional Advisory Group has guided us wisely. Dr. E. Harvey Estes is Chairman of this Regional Advisory Group, and there are six representatives-at-large from the Medical Society of the State of North Carolina that were appointed by Dr. John Glas-son. These individuals are Dr. Edgar T. Beddingfield, Jr., Dr. Joseph G. Gordon, Dr. John A. Brabson, Dr. John R. Chambliss, Dr. George W. Paschal, Jr., and Dr. Louis deS. Shaffner. There are 11 other physicians on our Regional Advisory Group which has a total membership of 49. The loyalty and dedication of these physicians as well as their fellow members on the Regional Advisory Group has been a great factor in the continued operation and success of the NCRMP.

In addition, through the efforts of Dr. Ron Davis, the NCRMP has supplied information monthly to the North Carolina Medical Society via the *North Carolina Medical Journal*, a summary of continuing education activities in North Carolina and neighboring states. This information is entitled "What? When? Where? In Continuing Education." Furthermore, Dr. Davis has worked closely with the staff of the Medical Society at its office in Raleigh.

The future of our Program is undoubtedly questionable since the legislation expires on July 1, 1974. The likelihood is that the Program will be extended at least until July 1, 1975. A far-reaching bill (HR 12053) was introduced into Congress in January 1974 transferring the functions of Regional Medical Programs, Comprehensive Health Planning and Hill-Burton to new entities called Health Service Agencies. This proposal will warrant heated debate, and I doubt if the transition will occur before January 1, 1975 even if the bill is passed by Congress and signed by the President.

F. M. Simmons Patterson, M.D., Executive Director

COMMITTEE ON RELATIVE VALUE STUDY

(Report not received April 10, 1974)

COMMITTEE ON RETIREMENT SAVINGS PLAN

The Committee on the Retirement Savings Plan is pleased to present its report for the year 1973. During the year the Committee met at the conclave in Mid Pines and all members were present with the exception of one. At that time the Committee heard a report on the operation of the NORTH CAROLINA MEDICAL RETIREMENT SAVINGS PLAN from two trust officers from Wachovia Bank & Trust Company, the Trustee. Other routine business was transacted.

As is apparent to all investors the stock market equities dropped sharply in 1973 and most retirement plans were affected adversely in some way. On the other hand the decrease in stock prices provided the opportunity for suitable acquisitions which were made during the year. Although the market value of the stock portfolio dropped considerably during the year we are pleased to report that the assets of the Plan continued above two million dollars at the end of 1973 and income on the diversified portfolio was over \$75,000.00.

At the present time only a few physicians are taking down benefits from the Plan. Apparently because of the

good performance in 1972 we have enrolled a number of participants who have switched to the NORTH CAROLINA MEDICAL RETIREMENT SAVINGS PLAN from other Keogh plans.

The Committee wishes to advise the membership again about the insured savings portion of the Plan which provides a method of saving for retirement which would not fluctuate with the stock market.

Jesse Caldwell, M.D., Chairman

COMMITTEE ON SCIENTIFIC AWARDS

Following the annual meeting of the North Carolina Medical Society in May 1973, the scientific papers selected by the various specialty organizations were secured and distributed to the members of the Committee on Scientific Awards. On September 28, 1973, the Scientific Awards Committee met at Mid Pines and made the following selections for awards:

"An Experience with a Skin Cancer Detection Clinic at A State Fair" by Dr. Elizabeth Kanof, for the Wake County Award

"The Role of Gastroesophageal Reflux in Nocturnal Asthma in Children" by Dr. Susan Dees, for the Moore County Award

The Committee reaffirmed its previous approval of the principle of the Durham-Orange County Annual Scientific Award for the outstanding clinical paper submitted yearly by a medical student or house officer.

David S. Citron, M.D., Chairman

COMMITTEE ON SCIENTIFIC EXHIBITS

The members of the Committee on Scientific Exhibits were well pleased with the group of exhibits which were assembled for the 1973 Annual Session. Our effort at a competitive exhibit, in order to stimulate attendance, was moderately effective.

A news letter of appreciation was circulated to both scientific and technical exhibitors shortly after the Annual Meeting.

Invitations have been issued to scientific exhibitors for the 1974 Annual Session. We hope to have a well rounded group of exhibits and are striving to attain greater attendance.

Josephine E. Newell, M.D., Chairman

COMMITTEE ON SOCIAL SERVICE PROGRAM

The Committee on Social Service Programs during the past year has been concerned primarily with Medicaid. These claims have been handled entirely by the Department of Social Services this past year and the change in the handling of these claims on the whole has gone smoothly. There have been some instances of over-utilization which are in the process of review. The committee held only one meeting, this being at the Committee Conclave at Mid Pines in September, 1973. In the interim liaison has been maintained by the committee chairman with Mr. Sellers of the Department of Social Services and Dr. Watson of the professional staff of this department.

J. S. Mitchener, Jr., M.D., Chairman

COMMITTEE ADVISORY TO MEDICAL STUDENTS

At the annual meeting of the N. C. Medical Society May 19-23, 1973, a change in the Constitution was passed by the House of Delegates—to wit: “any student who is regularly enrolled as a candidate for the degree of Doctor of Medicine in a school in the state of North Carolina shall be eligible for Student Membership.” This eliminates the previous requirement of SAMA membership as a prerequisite. Final action on this change will be in 1974.

During the 1973 meeting at Pinehurst, an informal luncheon was arranged for students and practicing physicians. This was an unqualified success! Students attended many specialty sections as well as the general sessions and actively participated. Delegates from Duke, Bowman Gray, and UNC participated in the deliberations of the House of Delegates.

There continues to be increasing interest in the N. C. Medical Society by students. The student members are anxious to serve on committees and to contribute to the advancement of the Society.

Oscar L. Sapp, III, M.D., Chairman

AD HOC COMMITTEE ON CONSTITUTION & BYLAWS REVISION

Nothing to report at this time

Louise deS. Shaffner, M.D., Chairman

AD HOC COMMITTEE TO STUDY AND RECOMMEND A SALARY OR INCREASE IN ALLOWANCES FOR THE PRESIDENT

The full committee met at Mid Pines on September 19, 1973 for the consideration of its charge.

This committee was appointed by President John Mason at the direction of the House of Delegates of the North Carolina Medical Society at the annual meeting in Pinehurst in May, 1973.

This was the result of action taken relative to Resolution No. 3 introduced by the Pitt County Medical Society which provided “that the President of the North Carolina Medical Society will be paid a salary of \$25,000 per year” and that the President will continue to be paid all reasonable expenses incurred in performing North Carolina Medical Society duties.

Following consideration and discussion before Reference Committee II, the House of Delegates received from them a substitute resolution in which it was resolved “that a method be made to increase the allowances for the President of the Society” and “that this matter be referred to an ad hoc committee appointed by the President for further study and recommendation.” In developing our recommendations we prepared and distributed a questionnaire to each of our fellow State Medical Societies to determine what is being done in other states. Information received covered:

- the number of full-time and part-time employees
- size of annual budget
- does the President receive a salary, and if so, how much?
- does the President receive pay for outside secre-

tarial and/or office expenses, either on a fixed or reimbursable basis

5. does the President receive travel expenses and if so is he paid on a fixed annual or monthly allowance or on an actual reimbursement basis?

Of the 44 responses we learned that we were among the 12 responding states with a budget in excess of \$500,000. Only eight per cent of the states pay their President compensation, ranging from \$1,000 to \$10,000. Ten of the states provided states funds for secretarial help and nine states pay for secretarial help on a reimbursable basis. Only four states do not pay for travel expenses. The Charter of the North Carolina Medical Society does not prohibit it from paying the President for services rendered. Such payment does require that he come under the same provisions of any other of its employees.

The recipient of funds would be required to treat such monies as income. Here in North Carolina we feel that with our coverage for travel and costs incurred plus the provision for secretarial help that we actually exceed the \$10,000 salary provided by some states.

We find complete agreement within the committee that the President should receive a generous allowance for expenses incurred, but that a definite salary should not be provided.

Based on these and other considerations, we submit the following statement for the information of the Council. This same statement will be forwarded to the Speaker of the House of Delegates for consideration by them at the next annual meeting:

We recommend that the Society continue to pay reimbursable expenses attendant to the President including necessary travel, housing, food, communications, and out-of-pocket secretarial expenses; and that in addition, the Society pay a per diem at the rate of \$25 per day for days or parts of days spent by the President outside of the home town on Society business.

We further recommend in alleviating the burden of assuming the Presidency that the President-elect and the immediate past President be reimbursed for their travel and living expenses when by virtue of their office they are involved in official Medical Society functions.

We estimate that the cost incidental to the implementation of the first recommendation will be about \$2,500 and of the second, about \$1,500.

Edgar T. Beddingfield, Jr., M.D.

Louis deS. Shaffner, M.D.

T. Tilghman Herring, M.D.

George W. Paschal, Jr., M.D., Chairman

NORTH CAROLINA BOARD OF MEDICAL EXAMINERS

STATISTICS

November 1, 1972-October 31, 1973

Total number of applicants granted license.....	722
By endorsement of credentials.....	486
By written examination.....	236
Examination failures	60

Limited licenses	92
Hospital residents	5
County or counties	87
Resident's training license	296
Applicants rejected license by endorsement of credentials	3
Did not meet requirements of the Board	
Applicants declined permission to take written examination	0
Hearings	31
Drug addiction	4
Mishandling of drugs	19
Petitioning for reinstatement of narcotic registration	3
Over-utilization of Medicaid billings	1
Routine follow-up	6
License to practice medicine revoked	0
Surrender narcotic tax stamp	0
Declined reinstatement narcotic tax stamp	2
License to practice medicine reinstated	0
Investigation by SBI	2

COMMISSION FOR MEDICAL FACILITY SERVICES AND LICENSURE

Report on Activities for the Calendar Year Ending December 31, 1973

Medical Facility Planning and Construction

During 1973, 28 medical facility projects receiving State and Federal aid were underway. Total cost for these projects is \$139 million; they will provide 1,800 additional beds. The 28 projects involved 15 hospitals, 3 nursing homes, 2 mental health centers, 2 facilities for the mentally retarded, and 1 rehabilitation facility. In addition to these, the Construction Section has been readying during the year 4 other health facility projects, estimated to cost more than \$18 million that can be initiated when and if Federal appropriations are released. This represents a decline in activity from the previous year when the staff was readying 7 construction projects estimated to cost \$36 million. This decrease is due to the Federal cutback in grant funds to health care facilities.

North Carolina ranks second among all the states in the number of health facility projects constructed under the Hill-Burton Act.

Scholarships for Medical and Related Health Studies

Recipients of the Division's educational loans agree upon completion of their training to repay their loans by one calendar year of service for each year they received funds. In 1973, 402 applicants were approved. The year's new participants bring the current in-school total to 677. An additional 171 recipients are in a deferred status (postgraduate training, military service or sick leave) providing a potential manpower contribution

of 848. Of the 848, 286 are in nursing, and 242 are in medicine. During 1973, 108 recipients entered practice arrangements consistent with the needs of the State, making a total of 269 practitioners currently providing service in 13 different health professions. Five of those beginning practice this year were physicians—each with four-year commitments.

Physician Recruitment

A pilot program was authorized by the 1973 legislature to offer incentives to physicians who would practice in medically deprived areas. Two measures have been authorized by the Commission for Medical Facility Services and Licensure. One is the provision of stipends for residents whose field practice is in a rural community or a medically deprived area. The second measure involves the partial reimbursement of costs incurred by a community in recruiting a physician. As the program has been in existence for only a few months, and is obviously somewhat dependent on restructuring of medical training programs, it was not possible to place any physicians in 1973. Communities and residents have demonstrated interest in both programs, however, and a number of areas should obtain medical services through these efforts in 1974.

Hospital Licensure and Medicare Certification

During the year, 156 hospitals involving 31,505 beds were licensed as meeting the Commission's standards for patient care and safety. Many of these received consultation from the Commission to help them retain eligibility to admit patients under the Medicare and Medicaid programs. The number of hospitals complying with Federal criteria represents 97 of the total in operation.

Economic Stabilization Program

Appointed by the Governor as the State Advisory Board for North Carolina during Phase II of the Economic Stabilization Program, the Division reviewed requests from hospitals and nursing homes for increases in charges in excess of limitations set forth in Cost-Plus Living Council health regulations. The Division acted on 27 applications for exceptions in 1973 as compared to 26 application reviews in 1972.

Administrative Reorganization

The administrative staff of the Commission for Medical Facility Services and Licensure has been combined with several other administrative units of the Department of Human Resources to form the Division of Facility Services. Consolidated in this Division are those activities relating to licensing, certification, regulation, inspection, and registration of health and social service facilities and organizations. The Division also includes the newly created Emergency Medical Service and Rural Health Sections.

I. O. Wilkerson, Jr., Executive Secretary

Executive Council

Summary of Minutes of Meetings of the Executive Council

NOTE: As recommended by the Finance Committee, the Executive Council authorized that just the salient actions of the Executive Council will be reported in brief form.

The verbatim transcript of the Executive Council minutes are on file in the Headquarters Office and may be reviewed or pertinent portions excerpted on request.

FALL EXECUTIVE COUNCIL MEETING

September 30, 1973

(Morning Session)

—The Fall meeting of the Executive Council convened at 9:10 a.m. in the Meeting House of the Midway Club, Southern Pines, N. C., Dr. George G. Gilbert, President, presiding. Past President Dr. John Glasson gave the invocation, following which Dr. Gilbert recognized new Councilors in attendance and also new commissioners.

—President Gilbert announced with regret that First Vice-President Dr. Michael F. Keleher, had had to resign all extracurricular activities because of health, including the vice-presidency of the State Society. So that token and in keeping with the Constitution, Dr. D. E. Ward is automatically the First Vice President. Secretary Dr. E. Harvey Estes, Jr., called the roll and declared a quorum present.

—Mrs. J. Benjamin Warren, representing the Auxiliary, President, Mrs. J. Elliott Dixon, presented a brief report on the Auxiliary activities for the year 1973-74.

—Dr. William F. Hollister, Chairman, North Carolina Medical Education and Political Action Committee presented a brief report on the current activities of MedPac and AmPac, urging support of the Society leadership and encouraging the membership to join the organization and participate in its activities.

—Dr. T. Tilghman Herring, Chairman, Committee on Finance, presented the proposed budget for 1974, as a balanced budget, which was approved and adopted by the Executive Council. See separate REPORT A—REPORT OF THE EXECUTIVE COUNCIL, Page 63, HOUSE OF DELEGATES, May 19, 1974.

—The Executive Council approved a motion that an ad hoc liaison committee be appointed to meet with a similar subcommittee of the North Carolina Board of Medical Examiners to discuss the problems of dealing with those physicians who appear to be engaged in deviant or inappropriate practice of medicine in North Carolina and that the joint committee be instructed to report back to the Council at its next meeting.

—The Executive Council appointed Dr. John H. Harroe of Winston-Salem, to fill the unexpired term of Dr. Joseph B. McCoy, Jr., on the Committee on Blue Shield representing the Section on Obstetrics and Gynecology, the term expiring in 1976.

—The Executive Council appointed Dr. William W. Gray of Raleigh to fill the unexpired term of Dr. William R. Purcell, on the Committee on Blue Shield representing the Section on Pediatrics, the term expiring in 1976.

—The Executive Council appointed Dr. John Glas-

son of Durham to fill the unexpired term of the late Dr. Frank W. Jones, as a Delegate to the American Medical Association, a term expiring December 31, 1974.

—The Executive Council appointed Dr. Charles W. Styron of Raleigh to fill the unexpired term of Dr. John Glasson, as an Alternate Delegate to the American Medical Association, a term expiring December 31, 1975.

—The ad hoc Committee to Study and Recommend a Salary or Increase in Allowances for the President recommended that in addition to paying the reimbursable expenses that the Society pay a per diem of \$25 per day for days spent on Society business, and attendant to the President further recommended in alleviating the burden of assuming the Presidency that the President-Elect and the immediate Past President be reimbursed for their travel and living expenses when involved in official Medical Society functions. See separate REPORT B—REPORT OF THE EXECUTIVE COUNCIL, Page 63, HOUSE OF DELEGATES, May 19, 1974.

—The Committee on Peer Review recommended to the Executive Council that the Committee on Peer Review serve as a coordinating body to meet at frequent intervals with the review committees involved with claims review to coordinate problems. The Committee on Peer Review would make certain educational efforts as are deemed necessary in particular cases. If the Committee cannot correct the problem, it would refer it as a profile to the Mediation Committee for whatever action they deemed necessary. A motion that these recommendations be incorporated in the committee charges was amended to refer them to the Council on Review and Development and was then passed by the Executive Council.

—The Executive Council approved a motion that the State Society approves the North Carolina Medical Peer Review Foundation, Inc., presentation appealing for one statewide PSRO in the state and go on record as supporting the statewide PSRO concept.

—Past President Charles W. Styron, M.D., for the Council on Review and Development, reported that the Council planned to write to the Committee on Personnel and Headquarters and to the Committee on Finance recommending that the Society engage an additional headquarters staff member by reason of the heavy workload of the headquarters staff. In addition, he reported, it is hoped that a staff member can be assigned fully to legislative matters since it is one of the most important activities of the Society. He also

said the Council on Review and Development will recommend that the North Carolina Medical Society Foundation arrange a separate meeting during the year since the Foundation now meets for such a short meeting and has no opportunity to discuss the problems of the Medical Foundation.

(Afternoon Session)

—The Executive Council considered and recommended to the House of Delegates approval of a request from the Section on Ophthalmology and Otolaryngology to form a separate section for each as follows: A Section of Ophthalmology and a Section on Otolaryngology. See separate REPORT C—REPORT OF THE EXECUTIVE COUNCIL, Page 63, HOUSE OF DELEGATES, May 19, 1974.

—The Executive Council approved a recommendation of the Committee on Chronic Illness that the North Carolina Medical Society endorse the principle that long-term care facilities in North Carolina employ the services of a physician to serve as Medical Director. It also recommended and the Council approved, that the Society endorse the "Guidelines for a Medical Director in a Long-Term Care Facility" as adopted by the American Medical Association. See separate REPORT D—REPORT OF THE EXECUTIVE COUNCIL, Page 64, HOUSE OF DELEGATES, May 19, 1974.

—On recommendation of the Committee on Chronic Illness, the Executive Council approved that the North Carolina Medical Society continue to endorse Home Health Services and recommends the development and extension of Home Care to areas not having these services at the present time. Implementation of this recommendation to be encouraged through county medical societies.

—The Executive Council accepted as information the recommendation from the Committee on Chronic Illness for approval of the Statement regarding preventive use of isoniazid as a public health measure. The Statement had been recommended for approval by the Committee one year ago, was submitted to the House of Delegates, but the Reference Committee recommended that instead of adoption it be re-referred to the Committee for further consideration on the basis of some evidence presented at the Reference Committee having to do with the toxicity of certain drugs, etc. However, the Committee on Chronic Illness again recommended approval of the Statement.

—Approval was voted for a Committee on Chronic Illness recommendation for a renewed effort to identify and bring to treatment cases and potential cases of tuberculosis among the population. See separate REPORT E—REPORT OF THE EXECUTIVE COUNCIL, Page 64, HOUSE OF DELEGATES, May 19, 1974.

—Council approval was voted for a request from the Committee on Mental Health that the Reserve Funds for Mental Health purposes be used to pay expenses for key people to attend the Southeastern Regional Mental Health Meeting at Atlanta, Georgia.

—Recommendations from the Committee on Drug Abuse concerning proposed amendments to General Statutes were referred to the Committee on Legislation for their perusal.

—A recommendation from the Committee on Marriage Counseling and Family Life Education that a two-

hour program on sex education be held at the annual meeting was referred to the Annual Convention Commission.

—The Executive Council adopted a resolution, in the recommendation of the Committee on Marriage Counseling and Family Life Education, recording deep and sincere regret at the untimely death of Mrs. E. L. Nash early in 1973, a pioneer with sex education efforts and marital and sexual counseling in North Carolina.

—The Committee on Child Health recommended and the Executive Council approved that in light of its common occurrence and serious complications in regard to mortality and permanent brain damage, *Haemophilus influenzae* meningitis be named a reportable disease. See separate REPORT F—REPORT OF THE EXECUTIVE COUNCIL, Page 64, HOUSE OF DELEGATES, May 19, 1974.

—A recommendation from the Committee on Occupational and Environmental Health for strong endorsement and support for the development of speakers and assistance to the local county medical societies toward educational information on occupational health was referred to the Committee on Medical Education. A Committee recommendation urging the support of similar programs on occupational health at the annual meeting of the Medical Society in May when it could be accomplished was referred to the Committee on Arrangements. A motion from the Committee urging the State Society to endorse occupational health information to be disseminated in the curriculae of the medical schools of the State was received as information.

—The Committee on Legislation recommended and the Executive Council approved that the Society continue its current way of operating in the implementation of PSRO's that the Society not join in any effort to have PSRO repealed in the U. S. Congress. The Committee also recommended and the Executive Council approved that the Society continue its support of AMA Medicaid legislation with the addition of dental services to the proposed legislation.

—The Executive Council passed a motion approving of the actions of the Committee on Legislation in its interest in possible legislation that would make record of peer review committees, non-discoverable in court proceedings.

—The Executive Council approved the recommendation of the Committee on Legislation that the Council approve the Committee's continued opposition to Senate Bill 556, having to do with the definition of optometry.

—Approval was given to participation with the Smith Kline and French pharmaceutical firm in a program called Practical Politics Seminar, a program where the Society invites the health leaders in the General Assembly to a weekend seminar about the political process with the expenses of the legislators being paid by the pharmaceutical company.

—It was reported as information that the Medical Legal Committee, as a follow up to the AMA medical survey on medical services in jails, will send a more comprehensive questionnaire to each Chairman of the Board of County Commissioners with copies to the officers of the county medical society.

—The Committee on Eye Care and Eye Bank brought several items as information to the attention of the Council. The Committee recommended to the Society

ophthalmologists and to the Department of Social Services that a prior approval policy for Medicaid recipients be implemented by the Department for routine eye examination for fitting eye glasses to prevent duplication of services. It was also pointed out that there is a remarkable shortage of eye descriptive procedures in the RVS as it exists at the present time limiting reimbursement for services provided. The Committee also recommends approval for use of soft contact lenses be limited to therapeutic use and only then with prior approval in order to limit indiscriminate use of soft contact lenses.

—The Committee Liaison to the North Carolina Pharmaceutical Association reported as information that a subcommittee with representatives from the Pharmaceutical Association will begin work on an updated version of the booklet, "Physician-Pharmacy Code of Understanding."

—The Committee on Public Relations reported a number of items as information, including the following: A Synopsis and Recommendations for Improvement of Medical Services in North Carolina has been distributed; Recommendations for initiating a program of periodic news releases has been planned; A Joint Statement of Policy on Donation of Human Tissue for Transplantation, as approved by the Society, has been approved by the N. C. Hospital Association and is to be printed and distributed; The Conference on Medical Leadership is to be held on February 1st and 2nd in Raleigh and the Committee recommends that an in-depth review and analysis of the existing external public relations programs by the Society be undertaken.

—The Committee on Disaster and Emergency Medical Care reported as information that a new Division is being established in the N. C. Department of Human Resources to be known as the Emergency Medical Services Division and members of the Medical Society Committee are assisting in the implementation of the program.

—The Committee on Association of Professions noted as information the need for increased participation by physicians in the Association of Professions organization.

—The Committee on Community Medical Care reported as information that it endorsed the Governor's Rural Health Program as an example of an experimental model health care system; that the Committee had prepared suggested guidelines for a program funded by the last Legislature whereby residency programs in primary care in communities across the state would reduce the students translocation expense for the period of time the student is to spend in the community to make electives in community medicine; and expressed a need for a comprehensive plan by the Medical Society for meeting the problem of maldistribution of physicians and too few primary care physicians.

—The Insurance Industry Committee recommended that the Executive Council voted approval, that the Society go on record as opposing Senate Bill 932 before the General Assembly, a bill which would remove the requirement of coordination of benefits from health insurance coverage.

—The Insurance Industry Committee reported as information, its recommendation that the Society go on record supporting the concept of insurance carriers providing maternity benefits for unmarried female minors. It also reported that the committee has appointed a

subcommittee to develop a proposed definition and guidelines for "custodial care."

—As an information item, the Committee to Work with the N. C. Industrial Commission recommends May 1975 as the date when the N. C. Workmen's Compensation Fee Schedule should be updated and that it should be updated every two years thereafter.

—The Executive Council approved a motion to refer to the Committee on Hospital and Professional Relations to serve as the coordinating representative of the State Medical Society with the North Carolina Hospital Association relative to a recommendation from the Committee on Hospital and Professional Relations that this Committee approves in principle the request of the North Carolina Society of Internal Medicine to study methods of improving medical records and that the North Carolina Medical Society and North Carolina Hospital Association should in consultation form a committee to study and demonstrate solutions to this problem and employ professional consultants if necessary.

—The Committee on General Sessions Program presented a progress report, as information, on its efforts to present a strong program of continuing medical education at the first and second general sessions and that the third general session be socio-economic in content.

—The Committee on Arrangements reported as information a number of changes in the program format being planned for the Annual Meeting including: (1) a strong scientific program for the first and second general sessions with a socio-economic program for the third general session, (2) the Memorial Service to be united with a Prayer Breakfast, (3) pins and certificates for the Fifty Year Club to be presented at each member's respective county society, (4) AMA-ERF checks to be presented to their recipients during the Auxiliary program, (5) the Nurse of the Year Award to be made at the annual meeting of the N. C. Nurses' Association and presentation of awards of the Moore and Wake County medals will be made by the Committee on Awards in an appropriate manner via the respective county societies of the recipients.

—The Committee on Arrangements recommended that the Executive Council approve September dates for the annual meeting beginning in 1975 or as soon thereafter as possible. The Executive Council voted approval of the motion. A following motion passed by the Executive Council instructed that the Executive Director and staff prepare a questionnaire to the membership concerning the question including choice of dates as May opposed to September. See separate REPORT G—REPORT OF THE EXECUTIVE COUNCIL, Page 65, HOUSE OF DELEGATES, May 19, 1974.

—The Committee on Cancer recommended that the State Society emphasize and call attention to the value of the State Board of Health's Certified Home Health Agencies services so that the physicians in different counties might be aware of these services. This being a concurring recommendation with an earlier recommendation from the Committee on Chronic Illness, no action was deemed necessary.

—The Committee on Medical Education recommended implementation of a program of compulsory continuing education, including four points in their recommendations, which were approved by the Executive

Council. Principle among them was "that a minimum of fifty hours of continuing education per year be required of each member of the State Society." See separate REPORT H—REPORT OF THE EXECUTIVE COUNCIL, Page 65, HOUSE OF DELEGATES, May 19, 1974.

—The Committee on Constitution and Bylaws recommended that the Executive Council establish a format and policy for the correct submission of resolutions. However the discussion seemed to indicate a consensus that this could be handled administratively so no action was taken.

—The Committee on Relative Value Study is approaching proof form. Final drafts will be reviewed by the committee as soon as practicable.

—The Committee Advisory to the Department of Motor Vehicles reported as information that it wished to change its name to Committee on Traffic Safety inasmuch as it now has a broader scope of activity more in keeping with the new name.

—The Committee of Physicians on Nursing expressed a desire to change its name to Committee on Allied Health Professionals since it is now involved with areas other than nurses. It also reported as information that "the committee has considered the concept of independent fee-for-service for care rendered by physicians' assistants, nurse assistants, nurse practitioners and similar individuals and rejects this concept as invalidating physician responsibility for medical care." It was also reported that the Committee voted to drop the Nurse of the Year Award for next year.

—The Committee on Comprehensive Health Service

Planning recommended follow up effort by the Society in two particular areas: (1) that the physicians be encouraged to participate in the various subdivisions and task forces on Comprehensive Health Planning agencies; and (2) that the Society follow up in its efforts to get practicing physicians on the Governor's Advisory Commission on Comprehensive Health Planning.

—The Executive Council approved a motion requiring the Committee on Constitution and Bylaws to prepare a suggested change to the Constitution and bylaws regarding local membership in a medical student body organization in lieu of Student American Medical Association membership as a prerequisite to membership in the State Society.

—The approval was voted for a Committee on Personnel and Headquarters Operation request that the hiring of an additional headquarters staff person to serve as a file clerk be approved.

—Tentative dates for the September Committee Cclave were announced for future years as follows: September 25-29, 1974; September 24-28, 1975; September 22-26, 1976; September 28-October 2, 1977; and September 27-October 1, 1978, all scheduled to be held at the Mid Pines Club. The Executive Council voted confirmation of the 1974 dates.

—The Executive Council approved a motion that the Secretary write a letter of sincere appreciation to Joseph J. Combs, M.D., for his faithful service over the many years that he has served as Secretary of the Board of Medical Examiners of the State of North Carolina.

MID-WINTER EXECUTIVE COUNCIL MEETING

February 3, 1974

(Morning Session)

—The Mid-Winter Meeting of the Executive Council convened at 9:00 a.m. in the Executive Council Room of the Medical Society building, Raleigh, N. C., President George G. Gilbert presiding. Vice-Speaker of the House of Delegates, Chalmers R. Carr, gave the invocation. In the absence of the Secretary, the Executive Director, Mr. William N. Hilliard, called the roll and declared a quorum present.

—Dr. T. Tilghman Herring, reporting for the Committee on Finance presented the Audit for the 1974 calendar year and reported that the remaining portion of the mortgage on the Greenfield property was paid off ahead of schedule and it was also possible to pay off the loan for building the Society building. The Council voted approval of the Report of the Committee on Finance.

—Dr. H. David Bruton, Chairman, Committee on Legislation, reported on current status of various measures before the 1974 General Assembly. Approval was voted for a motion that the Committee on Legislation be instructed in whatever manner they deem necessary to oppose Senate Bill 1014 and identical House Bill 1450, a health reimbursement plan that payment by insurance carriers and third parties be determined on a usual, customary and reasonable basis with respect to the entire state and not made on geographical basis. Opposition to Senate Bill 932, a Bill which would

eliminate coordination of health insurance benefits, was also approved by the Executive Council. The Council voted to instruct the Committee on Legislation to oppose Senate Bill 1002, a bill requiring that there be no suspicion that criminality exists before the Medical Examiner's autopsy can be ordered. Support was approved for House Bill 1303 and Senate Bill 913 which would remove the thirty day waiting period for sterilization. The Executive Council voted to support the bills on mental health, one regarding voluntary commitment and one regarding involuntary commitment. Senate Bill 981 and 990.

—A motion was passed that a letter be written to the Department of H.E.W. in support of the AHA position protesting the proposed regulation requiring precertification for hospitalization except in cases of emergency. A motion was also passed to send a telegram to each North Carolina Senator urging that they vote against extension of an extension of economic stabilization act, a copy of the telegram to be sent to the Senate Banking Committee.

—The Executive Council considered a resolution from Wake County which requested proposing legislation regarding protection for physicians with regard to "Informed Consent," however the discussion seemed to indicate that this subject was not one lending itself readily to a legislative solution. As a result the Council approved a motion that a letter be written to Wake

County Medical Society giving them the benefit of this discussion and ask them to either withdraw the resolution or it will be presented to the House of Delegates.

—A resolution from the Edgecombe-Nash County Medical Society, proposing repeal of the Professional Standards Review Organization (PSRO) legislation, was received and will be passed on to the House of Delegates. See separate Resolution No. 1.

—A resolution from the Fifth District Medical Society on the subject of "Increased Activity in the Area of Public Relations and Legislative Contact," however, it was the consensus of the Executive Council that it would be better form if a component society (county society) or an individual delegate were to submit the resolution since a district society has no delegate in the House of Delegates to speak on behalf of the proposal. It was suggested that the District Councilor seek to have the resolution introduced by a county in the district or by an individual delegate.

—The Executive Council considered a legislative proposal submitted by Pitt County Medical Society, a sample bill, which would require that anyone seeking a license to practice in several health related professional areas listed in the bill would have to be a graduate of a school which has been accredited by a recognized accrediting agency. A motion was passed referring the proposed bill to the Committee on Legislation for further study.

—A request from the Vital Statistics Division of the Department of Human Resources for State Medical Society support for changes in the death registration system was presented by Dr. Jacob Koomen, Director, Division of Health Services, and the Executive Council went on record as supporting the proposed changes and that a letter be written to the appropriate department advising of the fact that the Executive Council endorsed the proposal.

—The Executive Council voted approval of two measures having to do with traffic safety, the first Senate Bill 89 and the comparable bill in the House which makes blood alcohol of .10 prima facie evidence of intoxication. The Council also passed a motion reaffirming its support of mandatory seat belt legislation.

—The Executive Council approved the recommendation of the Chairman of the Committee on Public Relations that future meetings of the Conference on Medical Leadership held near the last of January be held in Raleigh again next year and that the dates in January held at the Pinehurst Hotel be released.

—Approval of a direct State Society Membership for Dr. James J. Richardson, was disapproved, but with the recommendation that he be instructed that his application will be reconsidered contingent upon renewal of his membership in the Scotland County Medical Society in compliance with the State Society's prerequisite of County Society membership to be eligible for State Society membership.

—Approval was given for accepting former student member, Colin Douglas Jones, as an out-of-state Intern-Resident member in the State Society, in order for him to continue his membership.

—A motion was approved by the Executive Council that the Committee on Constitution and Bylaws be requested to consider a change in the Bylaws whereby physicians in postgraduate training in accredited institutions outside North Carolina be admitted to Intern-Resident membership.

—The Executive Council considered Resolution No. 12 (1973 Annual Session) which was referred to the Executive Council for further consideration. In connection with the referral back to the Council, a letter from Past President Louis Shaffner commenting on the resolution was reviewed along with this suggestion for its handling. After discussion, the Council approved a motion that the Council accept Dr. Shaffner's recommendation and take no further action, but report his statements to the House of Delegates along with the fact that the UNC Board of Governor's Study fulfills the request of the Forsyth County Medical Society. See separate REPORT I—REPORT OF THE EXECUTIVE COUNCIL, Page 65, HOUSE OF DELEGATES, May 19, 1974.

—Affiliate membership status was approved for Joseph M. Hitch, M.D., on the recommendation of the Wake County Medical Society.

—Reappointed to the Board of Directors of the North Carolina Association of Professions, representing the Medical Society, were the following: Thomas G. Thurston, M.D., of Statesville; Edward K. Isbey, Jr., M.D., of Asheville; and George G. Gilbert, M.D., of Asheville.

—The Executive Council received a request from the newly organized North Carolina Neurosurgical Society that a Section on Neurological Surgery be formed in the State Medical Society. The request was approved by the Council and recommended to the House of Delegates for approval. See separate REPORT J—REPORT OF THE EXECUTIVE COUNCIL, Page 65, HOUSE OF DELEGATES, May 19, 1974.

(Afternoon Session)

—Secretary of the Board of Medical Examiners, Charles B. Wilkerson, Jr., M.D., reported as information that the Board of Medical Examiners has set up rules, regulations and procedures whereby the so-called outpatient or out-of-hospital based nurse practitioner can apply for registration in that category, and he also reported that the University of North Carolina nurse practitioner training has been approved by the Board. On another subject, he reported that it is not legal for a foreign doctor who is not licensed in the State to serve as a medical assistant or doctor under the sponsorship of another doctor. Finally, he reported that the Medical Practice Act states that when a licensed doctor of medicine in the State has been adjudged guilty of a felony that he may be investigated, called on to explain the situation and that his license may be considered for revocation. At the present time there are two instances where licensed doctors of medicine have been convicted of a felony and are now serving time, but while a person is incarcerated the Board has no access to him and since state law prevents revoking a license without giving the individual a hearing these cases are being kept under consideration.

—Dr. W. Joseph May, Chairman, Committee on Maternal Health, presented a report on behalf of the Governor's Task Force on Regional Planning for Maternal and Infant Care. The regionalization plan is proposed, he said, in large part because there is an excess of delivery facilities in North Carolina, so the regionalization concept is proposed in an attempt to bring about a gradual voluntary program of consolidation. The I, II, and III classes of stratification of hos-

pitals is in accord with the National Task Force on Perinatal Health and has the endorsement of the American College of Obstetrics and Gynecology, the American Academy of Pediatrics, and the American Academy of Family Physicians. The Executive Council endorsed the proposal and voted to send that endorsement to the North Carolina Legislature with a request for funding and implementation.

—Dr. J. Benjamin Warren, Vice President of the North Carolina Medical Peer Review Foundation, reported on the highlights of a meeting, the day before, of the Board of Directors of the Peer Review Foundation. The principal actions reported included: (1) a report from the President of the Foundation on his trip to Washington along with Medical Society Attorney Mr. John Anderson to explore the chances of North Carolina being designated a statewide single PSRO area. It was pointed out that four PSRO's of the size now proposed would not be manageable so it is being recommended that the State be divided into eight or more PSRO's; (2) the Peer Review Foundation apply for and assume the role of a medical resource center (MRC) to help the PSRO's set up and become functional; (3) a Committee on Norms was established; and (4) action was taken to employ Mr. Dan Mainer, the Society's Assistant Executive Director, on a full-time basis as Executive Secretary and to establish a fringe benefits package which would be equal to the North Carolina Medical Society package. On the fringe benefits package portion of the last item, the Execu-

tive Council passed a motion authorizing Mr. Anderson to implement an amendment to the Medical Society plan whereby a transfer of retirement between the Medical Society and the Peer Review Foundation would be possible.

—The Executive Council considered a proposal to participate with four other southeastern states in leasing a jet airplane for travel to the Annual Meeting in Honolulu, Hawaii, in 1975 and authorized the Executive Director to book forty seats for North Carolina.

—A proposed position paper on "Need for More Better Distributed Primary Care Physicians" was presented from the Committee on Community Care by Dr. John L. McCain, as Commissioner. After considerable discussion, the Executive Council voted to commend the Committee on Community Care for doing an outstanding job and that the proposed position paper be widely publicized and referred to the House of Delegates at the Annual Meeting in May. See separate REPORT K—REPORT OF THE EXECUTIVE COUNCIL, Page 65, HOUSE OF DELEGATES, May 19, 1974.

—Approval was voted for a motion to write a letter to Mr. John Ketner, of the North Carolina Hospital Association staff expressing appreciation and acknowledgement of the fine service he has provided in his health in North Carolina in bringing hospital and Medical Society closer together.

ANNUAL EXECUTIVE COUNCIL MEETING

May 5, 1974

(Morning Session)

—The Annual Meeting of the Executive Council convened at approximately 9:00 a.m. in the Executive Council Room of the Medical Society Building, Raleigh, N. C., President George G. Gilbert presiding. Past President John Glasson gave the invocation, and in the absence of the Secretary, the Executive Director Mr. William N. Hilliard called the roll and declared a quorum present.

—The Council reviewed the lettered reports "A" through "K" and "M" as contained in the delegates kits which were accepted for referral to the House of Delegates, all having been developed on the basis of previous Council action.

—The Council reviewed the numbered Resolutions 1 through 13 and approved that they be accepted for referral to the House of Delegates as presented.

—The Council reviewed a resolution, on the subject of "Delineation of Hospital Privileges by Specific Procedure," submitted by the Beaufort-Hyde-Martin-Tyrell-Washington County Medical Society and received after the normal deadline for acceptance of resolutions by the Headquarters Office. A motion was approved that this resolution be accepted and referred to the House of Delegates for consideration by Reference Committee II, to be considered along with Resolution No. 4, and that it be listed as Resolution Number 4-A. See separate RESOLUTION 4-A, Page 70, HOUSE OF DELEGATES, May 19, 1974.

—The Council approved acceptance of the Annual

Committee Reports as submitted in the Complete Annual Reports dated 1974. See separate copies of printed reports.

—Approval was voted for the purchase of a house and lot adjacent to the Medical Society parking lot fronting on Bloodworth Street, on the recommendation of the Chairman of the Committee on Personnel and Headquarters Operation and the Chairman of the Committee on Finance. Identified as the property is Mrs. N. G. Fonville, the property is 5,943 square feet. See separate REPORT N—REPORT OF THE EXECUTIVE COUNCIL, Page 69, HOUSE OF DELEGATES, May 19, 1974.

—On the recommendation of the Chairman of the Committee on Personnel and Headquarters Operation, approval was given to several proposals submitted by the Executive Director to the Chairman of the Committee concerning Headquarters Staff personnel assignments and job titles with appropriate salary increases.

—A motion was approved that the members of the Executive Council and members of the N. C. MedPac Board be given a specific invitation by the MedPac Board to become sustaining members of the North Carolina Medical Education and Political Action Committee and that the Executive Council record as supporting this endeavor.

—The Council approved a resolution endorsing N. C. MedPac membership on the part of members of the House of Delegates and that the resolution be forwarded to the House of Delegates for consideration.

the appropriate Reference Committee. See separate RESOLUTION 14, Page 72, HOUSE OF DELEGATES, May 19, 1974.

Nominees for the North Carolina MedPac Board of Directors were received and the following were

Ernest W. Larkin, M.D.
Marshall Redding, M.D.
Edgar T. Beddingfield, Jr., M.D.
John Watson, M.D.
John T. Dees, M.D.
Robert H. Shackelford, M.D.
James E. Davis, M.D.
Archie T. Johnson, M.D.
T. Lacy Stallings, M.D.
David Nelson, M.D.
John H. Hall, M.D.
Charles Hoffman, M.D.
William F. Hollister, M.D.
Lloyd H. Robertson, M.D.
Joseph Dameron, M.D.
John Henry Early Woltz, M.D.
A. Ledyard DeCamp, M.D.
R. Spencer Eaves, M.D.
T. Reginald Harris, M.D.
Wilburn Oscar Brazil, M.D.
Kenneth Cosgrove, M.D.

Auxiliary

Mrs. J. Elliott Dixon
Mrs. A. J. Crutchfield
Mrs. Edna Hoffman

—The Executive Council approved in principle, a proposed Plan of Assistance to Hospitals and Medical Affairs for Developing Full Time Emergency Room coverage as presented by Mr. William F. Henderson, Health Care Systems Consultant, former Executive Secretary of the North Carolina Medical Care Commission.

—The Executive Council approved the recommendation of an ad hoc Liaison Committee between the Board of Medical Examiners and the Medical Society, after minor word changes in the recommendation, to the effect that the House of Delegates be requested to

endorse an amendment to the North Carolina Medical Practice Act that the Board of Medical Examiners may revoke or restrict a license to practice medicine for lack of professional competence. See separate REPORT O — REPORT OF THE EXECUTIVE COUNCIL, Page 69, HOUSE OF DELEGATES, May 19, 1974.

—The Executive Council voted approval to recommendations of the Committee on Constitution and Bylaws concerning proposed changes in the Constitution and Bylaws. See separate REPORT P — REPORT OF THE COMMITTEE ON CONSTITUTION & BYLAWS, Page 57, HOUSE OF DELEGATES, May 1974.

—The Executive Council discussed the problem of implementing a change in the Constitution in regard to the compulsory continuing education as a requirement for membership in the Society approved by the House of Delegates in 1973. The Chairman of the Committee on Constitution and Bylaws indicated that it had not been possible for the Committee to meet on this subject but that he had some tentative Constitution and Bylaws wording regarding the compulsory continuing education as a requirement for membership for consideration by the House of Delegates in case they want to take action on this subject at this Annual Meeting. See separate REPORT Q — REPORT OF THE COMMITTEE ON CONSTITUTION AND BYLAWS, Page 58, HOUSE OF DELEGATES, May 19, 1974.

—The Executive Council approved a recommendation from the Chairman of the Annual Convention Commission that the Committee on Memorial Service be dissolved and that the duties of the Committee be assumed by the Committee on Medicine and Religion, and that the Committee on Constitution and Bylaws prepare the amendment to the Bylaws to effect the elimination of the Committee on Memorial Service.

—Dr. John W. Watson moved, and the Executive Council approved a Resolution to commend President George G. Gilbert for doing a fine job during the past year as President, since this was the last meeting of the Council over which President Gilbert would preside. The membership of the Council gave Dr. Gilbert a round of applause.

Abridged Minutes of the Meetings of the House of Delegates

SUNDAY AFTERNOON SESSION

May 19, 1974

The First Meeting of the House of Delegates at the 120th Annual Meeting of the North Carolina Medical Society convened at two-twenty-one o'clock in the Cardinal Ballroom of The Pinehurst Hotel, Pinehurst, North Carolina.

DR. GEORGE G. GILBERT [President of the Medical Society]: Hear ye! Hear ye! The 120th Annual Session of the North Carolina Medical Society is now declared in order and I will turn the podium over to our esteemed Speaker of the House of Delegates, Dr. James Davis.

DR. JAMES E. DAVIS [Speaker of the House of Delegates of the Medical Society]: Thank you, sir.

(The invocation was given by the Reverend Martin Caldwell, Rector of Emanuel Episcopal Church, Southern Pines.)

SPEAKER DAVIS: We welcome our visitors today. I'm delighted to see that there is a good number of them. We appreciate your being with us to make this 120th annual session and the annual meeting of the House of Delegates the valuable and memorable occasion we trust it will be.

With special pleasure, I now present to you your very able Vice Speaker, Dr. Chalmers Carr.

[Whereupon Dr. Chalmers R. Carr, Vice Speaker of the House of Delegates of the Medical Society, stood up to be recognized.] [Applause]

I realize also that your other officers are also known to you, not only by their appearance but by their good work, but I will ask our Vice President, Dr. D. E. Ward to stand and be recognized.

[Whereupon Dr. D. E. Ward, Jr., First Vice President of the Medical Society, stood up to be recognized.] [Applause]

And, our Secretary, Dr. Harvey Estes!

[Whereupon Dr. E. Harvey Estes, Jr., Secretary of the Medical Society, stood up to be recognized.] [Applause]

RECOGNITION OF PAST PRESIDENTS

Every organization owes a debt of gratitude, lasting gratitude, to its past leaders. Organizations, just as individuals, have become what they are because of and as a result of the past.

Most importantly, we are what we are because of the people who have influenced our lives, have changed and molded us into our present being.

So, it is with true delight today that we have with us, not really as guests because as you recognize these men are lifetime delegates to this House, but have with us as honorees men who have been so instrumental in changing and molding this Society into its present form.

Now, we have not suddenly nor recently become the organization which you and I know, a soundly structured, financially solvent Society of more than 4300 physicians, which not only speaks authoritatively for medicine in North Carolina, but constantly and conscientiously strives for more and better health care for all the people of North Carolina.

So it is with pride and humility that we present to

you our living Past Presidents of this Society. The accomplishments, of course, are legion, probably impossible to calculate and certainly I shall not attempt to enumerate them.

As each is presented, I will ask him to please stand to remain standing and I'll ask the House to withhold their applause until all have been presented.

Paul F. Whitaker, M.D., internist, Kinston, President in 1945.

Fred C. Hubbard, M.D., surgeon, Wilkesboro, President in 1952.

Donald Brock Koonce, M.D., surgeon, Wilmington, President in 1957.

Edward William Schoenheit, M.D., internist, Asheville, President in 1958.

John Conklin Reece, M.D., pathologist, Morganton, President in 1960.

Amos Neil Johnson, M.D., family physician, Garland, President in 1961.

John Sloan Rhodes, M.D., urologist, Raleigh, President in 1964.

George Washington Paschal, Jr., M.D., surgeon, Raleigh, President in 1966.

David Goe Welton, M.D., dermatologist, Charlotte, President in 1969.

Edgar Theodore Beddingfield, Jr., M.D., family physician, Wilson, President in 1970.

Louis deSchweinitz Shaffner, M.D., surgeon, Winston-Salem, President in 1971.

Charles Woodrow Styron, M.D., internist, Raleigh, President in 1972.

John Glasson, M.D., orthopaedist, Durham, President in 1973.

[As each past president's name was called each stood up at his place on the stage to be recognized.]

Gentlemen, we again recognize your past and your continuing contributions to our Society and the society at large. We express our gratitude to you and we trust that the good Lord will continue to bless you with good health, and longevity for many years to come.

[Whereupon the entire assemblage then accorded the Past Presidents a standing ovation.]

PRESIDENT'S MESSAGE

It is most appropriate that we now recognize and hear from our incumbent President.

All of us who have been privileged to work with George Gilbert over the past and previous years, and I think that this now must represent a large segment of our total membership, all I believe have been impressed with his sincerity, his conscientious approach to the duties of his office and to the problems of the Society and impressed that he is without doubt a man of conscience.

This past year must have been one of the busiest and most troubled years that medicine has seen so far, but through it all George has maintained his calmness and his quiet efficiency.

Wherever he has appeared as our spokesman, and I'm sure at this point it must appear to him to have

been endless, his quiet dignity, his thoroughness and his clear thinking have earned respect not only for himself but for our Society.

It is a genuine pleasure to present to you our President, Dr. George G. Gilbert.

[Whereupon the entire assemblage then accorded President Gilbert a standing ovation.]

PRESIDENT GILBERT: For once I don't have an appropriate joke like people often do after they get a blow-up like that, so I'll proceed with my little offering.

Mr. Speaker, Officers of the Society, Past Presidents, Members of the House of Delegates:

[Whereupon President Gilbert then read his prepared Message of the President to the House of Delegates, which was printed in the *North Carolina Medical Journal*, Vol. 35, No. 7, July 1974, p. 409) [Applause]

SPEAKER DAVIS: Thank you, very much, Dr. Gilbert and this address, of course, will be referred to the Committee on the President's Addresses.

MESSAGE OF THE PRESIDENT OF THE AUXILIARY

Just as the past year has been a busy and trying one for the Society, I'm sure the same has been true for the Auxiliary to the Society.

As many of you will recall, they celebrated their fiftieth anniversary last year and, so, the Auxiliary like a few of us present are now in the second fifty and trying hard to make it as good as the first fifty.

Fortunately for the Auxiliary, they have this past year had a very dynamic leader and at this time we will hear from her with her report from the Auxiliary, Mrs. Elliott Dixon, and I'll ask our Secretary, Dr. Estes, to escort Mrs. Dixon to the podium.

[Whereupon Mrs. J. Elliott Dixon, President of the Auxiliary to the Medical Society, was accorded a standing ovation.]

AUXILIARY PRESIDENT DIXON: Dr. Gilbert, Mr. Speaker, Dr. Carr and Members of the House of Delegates:

I would like to thank you for the opportunity of speaking to you this afternoon on behalf of your Auxiliary.

The activities of the Auxiliary during the past year are set forth in some detail in the Compilation of Reports, which you have already received. Therefore, I will not repeat that information.

I would like to go over a project that I personally have been interested in over the past three years. It has been presented in several areas of the state with very good response.

I am referring to the concept of the mini-health fairs. It comprises of a series of exhibits which are aimed at children from first through the fifth grades with the purpose of teaching the students some knowledge of their physical self and of those persons and situations in which he receives health care.

These have been exhibits using plastic models of the eye, the ear, joints, kidneys, skeleton, and in some a demonstration of a fresh beef heart has been used.

The instruments a physician uses in conducting a routine physical examination have also been available for the children to touch and demonstrations of their use have been conducted.

Two fairs included the equipment usually found in a

hospital room and operating room setup. X-rays were on display which showed a fracture film, a chest film, a skull film and a full term intrauterine pregnancy.

Our dental friends cooperated in providing an exhibit on dental hygiene and a variety of other areas of interest were included that related to health care.

In each area where these have been given, there has been overwhelming response by the students and a genuine interest and enthusiasm displayed.

In all of these, Auxiliary members have been responsible for initiating, gathering the materials to be used and were present to explain the demonstrations.

You may be approached by someone to use the models that are gathering dust in your office. Please allow their use and give whatever assistance you can to someone who wishes to put on a mini-health fair.

There are a few places in this state where this type of exhibit is on permanent display. While this is the ultimate, these temporary exhibits help to fill the gap.

This type of exhibit makes children more familiar with health related subjects and, hopefully, stimulates at an early age an interest in health careers.

Along the same line, I would also like to point out our efforts on behalf of AMA-ERF have been more successful this year than any one previous. So far, over \$14,000 has been raised for these funds and they will be distributed among the state's four medical schools.

The Auxiliary looks forward to continuing to work in the interest of organized medicine. Although the Auxiliary has its own role to play, we realize that we are only an integral part and hope that we can continue to represent its interests and aims whenever we have the opportunity. Thank you. [Applause]

SPEAKER DAVIS: Thank you, Betty, very much, and I hope you will once again remind all the members of the Auxiliary how much we appreciate and value their continued work in our interests.

HOUSE OF DELEGATES

Will the House please be in order?

Would Dr. Wilkerson please approach the podium?

In looking for people to be honored, we have recognized one more and we would now like to recognize and congratulate the man who has termed himself the lifetime Chairman of the Credentials Committee, Dr. Charles Wilkerson.

We've got a red carnation for him and after pinning that on him, we will ask him for this year's report from the Credentials Committee.

Dr. Wilkerson!

[Whereupon Speaker Davis then pinned a red carnation onto Dr. Wilkerson's jacket lapel.] [Applause]

DR. CHARLES B. WILKERSON, Jr. [Chairman, Credentials Committee]: Mr. Speaker, you have 176 duly certified delegates on the floor.

SPEAKER DAVIS: Thank you, Dr. Wilkerson, for a lifetime of duty!

As we get down to business, may I take just a moment to comment on the pamphlet that I hope all of you have received and I hope you have had a chance to review and you have with you.

This is simply guidelines compiled by your Speakers to help the House in smoothness and effectiveness of our actions.

I think that all of you realize that by bylaw requirement, following Sturgis's Rules and Regulations these

are simply abstracts which we think might be more readily referred to.

It is your Speakers' feeling that since this is a Compilation of rulings of abstracts from Sturgis bylaw requirements that it is unnecessary for the House to adopt this officially, simply because it is subject to correction or change at any time that you wish.

If you notice inside the back cover, there is a change by addition even before it got out of the press, so please don't feel that this limits or restricts you in anything that this House wants to do. This is only suggestions.

The question of a time limit on debate has also been raised and it again is our feeling that the procedure that we have followed, and that is to allow any speaker a reasonable period of time, certainly five minutes, and then allow him a second opportunity to speak if he so desires after everybody has had an initial opportunity, is a fair and equitable way of dealing with this without having a time kept on each speaker.

Again, we suggest that we continue to follow this, but this as any other rules of this House are subject to your judgment.

I should also like to point out that our session today for the first time has delegates from the specialty sections. In addition to the component county or hyphenated societies, many specialties, and they are listed in your handbook, have specialty representatives here and, therefore, when they speak will identify themselves as representing that specialty section rather than a component county society.

[Whereupon at this time Vice Speaker Carr assumed the Chair.]

VICE SPEAKER CARR: Mr. Speaker, Members of the House:

It is my duty to first introduce two speakers for short informal reports for information, not for action, and not for debate at this time.

First is Dr. Frank Sohmer who will speak on the current status of PSRO.

He is speaking to us as Chairman and Medical Director of the North Carolina Medical Peer Review Foundation.

DR. M. FRANK SOHMER, Jr. [President, North Carolina Medical Peer Review Foundation, Inc.]: Thank you, Mr. Speaker, Ladies and Gentlemen, it is with pleasure that I report to you as President of the North Carolina Medical Peer Review Foundation, Incorporated.

This organization was established with the endorsement of the Executive Council of this Medical Society in February of 1973.

The intent at that time was to respond to the PSRO legislation.

I have had the pleasure of serving as President of this organization since that time and with the very excellent Board, composed of many of the officers of this Medical Society, the following actions have taken place:

In September 1973 we made application to HEW for a single state PSRO designation. At no time have we changed our stance. We have been to Washington, we have talked to people in Atlanta. We continue to maintain this stance and as Dr. Gilbert has said, we now have eight PSRO's in this state. We have eight geographic designations. We do not have eight PSRO's.

An additional activity of this North Carolina Medical Peer Review Foundation has received an RMP grant and this was for educational seminars which we have

had fourteen—or, we're in the process of having fourteen. We have accomplished thirteen of these at this time.

In addition, we are establishing a Committee of Norms and this committee will develop criteria for standards for each PSRO to use only as guidelines, to be altered to implement each PSRO's activities.

It is not a cookbook that you're all going to have to practice by. It's only a guide to help you in the development of a program as required by the law.

I might say that copies of the presentation that was made with the educational seminars are at the desk; if any of you are interested in seeing the presentation that was made, this talk is available to you at the registration desk.

In addition, as Dr. Gilbert referred to earlier, we contracted with the Department of Human Resources to provide a quality of care review on all Medicaid patients in skilled nursing home facilities, psychiatric hospitals and tuberculosis center sanatoria.

We signed a year's contract in March of this year. We have been developing a program. The first actual on site review will take place on May 28th.

As many of you are aware, we have solicited physicians in the state to find out who's interested in serving on the review team. There will be four review teams in the state. The review teams will consist of a nurse and a social worker.

We envision using many, many physician reviewers to do on site review.

We have had over five hundred physicians respond and express interest in participating in this program.

In addition, we have made application to HEW for designation as a statewide support center and I might say there will be a statewide council. The statewide support center has nothing to do with the council.

Where there are three or more PSRO's, geographic designations, or potentially three or more PSRO's in a given state, HEW has seen fit to establish the designation as a statewide support center.

Our initial efforts, if we are approved and apparent we will be, will again be in an educational effort to make physicians aware of what the requirements of the law are and, in addition, in an organizational effort in the eight areas to aid those interested individuals and groups in establishing a non-profit corporation, to establish a PSRO.

We will continue to aid until that organization has made application for a planning grant.

Following this, after the organization has been developed and has made application for a planning grant, we would then only serve at the request of the individual PSRO as a service organization. We will provide administrative data, etcetera.

We would in no way have anything to do with local review, would have nothing to do with the direction of the individual PSRO and its activities.

We're hopeful that each individual PSRO organization as it develops will see fit to utilize the statewide support center for these purposes.

There has been no funding from the North Carolina Medical Society for this Foundation from its inception. None of your dues, no money has been received from the Medical Society for this Foundation.

We, at the present time, are renting space in the Medical Society building in Raleigh. We are paying the going commercial rate for this. We have paid the Medical

cal Society for all services that they have rendered to the Foundation.

All funds that have been received for this Foundation have been received from grants such as the RMP grant and from contracts such as the Medicaid nursing home contract.

Membership in the statewide Foundation is open to any licensed physician in this state, or to any doctor of osteopathy. We encourage your membership. We encourage your participation. We need your support. We need your input and applications are also available for membership at the desk.

Thank you, very much. [Applause]

VICE SPEAKER CARR: Thank you, Dr. Sohmer.

REPORT ON N. C. MEDPAC

We will now hear from Dr. Hollister on Med-Pac. DR. WILLIAM F. HOLLISTER: [Chairman, North Carolina Medical Political Education and Action Committee.] Mr. Speaker, Members of the House and Guests:

I welcome this opportunity to bring you a message on the activities of MedPac and the activities which have been going on in this past year.

Your MedPac Committee has been very active during this past year. The 24-member Board of Directors has met five times and will meet again this coming Monday night.

I'm pleased to report to you that your membership so far this year has already exceeded our total of last year by some 250 members.

When I became Chairman of the MedPac Board last May, one of my goals was to see to it that MedPac was known to every member of the North Carolina Medical Society.

At our first Board meeting, I asked each member to participate in a Speakers' Bureau so that any county society that requested a program concerning MedPac could have a member of the Board available to speak to their medical society at any designated meeting.

Also, Mr. Steve Morrisette of the headquarters staff, has spoken to several county medical societies and auxiliary groups.

I would like to have Steve rise. He's in the back of the room, because I want every member of the House of Delegates as well as members of the Medical Society to know Steve if you don't already.

Steve has been doing a great job in governmental and legislative affairs and the Executive Council has recently seen fit to allow an increase in his activities in governmental affairs, so that we hope that he will be your governmental and legislative liaison man between each component medical society and that you will be seeing more of him personally this coming year and in years to come.

Steve has been working very closely with Mr. John H. Anderson to develop an expertise in governmental and legislative affairs. John has been very helpful to him and will continue to do so.

John has given me permission to tell you that two members of his firm, Henry Mitchell and John Jernigan, will also be working with the Medical Society in

legislative affairs and governmental affairs these coming years.

Mr. Anderson has done a magnificent job this year, as Legal Counsel for the Medical Society, as always. So, there, you have the beginning of a new team which can more closely coordinate our governmental and legislative affairs with the affairs of your component societies.

We need the input of your component societies which I realize we have not had. We've not had the communications with the MedPac Board which we should have, but I can assure you that we have been working hard in that direction.

I feel that this initial beginning of communications on an eyeball to eyeball basis will cause the members of the North Carolina Medical Society to see the necessity for political action through your designated organization, MedPac.

In September we held our first workshop in conjunction with the Committee Conclave of the Medical Society. Those who attended the workshop felt it was most beneficial and we hope to have regional workshops in the coming year.

These workshops will provide physicians with background knowledge of the political process which is so vitally needed in our profession today.

We have also arranged with the headquarters office for a more efficient way of handling our membership and it will be possible in the next few months to get a print-out of all MedPac members in any given county medical society.

We feel that this will aid us in increasing our membership.

We also plan to establish a quarterly newsletter for MedPac members. This Newsletter will keep them informed of what's going on in the organization.

The MedPac Board voted at its last meeting to appropriate funds from our educational account for the purpose of producing a film about the state political action committee. This film has been completed and will be shown at the MedPac banquet tomorrow night, which I hope you will all attend. This film will be available to any county society or anyone else in the Medical Society who would like to use it. We have two copies of the film. We plan at this time to use the film as part of our presentation when we speak at county society meetings and at auxiliary meetings.

I would remind you that MedPac dues are only \$20 a year or \$100 a year for sustaining membership.

I would hope that every member of the Medical Society and particularly members of this House of Delegates would become members of MedPac and support your medical political action and educational organization.

Thank you very much for this opportunity to present this report to you.

[Applause]

VICE SPEAKER CARR: Thank you, very much, Dr. Hollister. We hope that your words will be heeded.

ANNUAL REPORTS

The next order of business is acceptance of the Annual Reports. The Annual Reports are contained in the Compilation which you have in your packet, the 1974 Compilation of Annual Reports. They emanate from various committees, commissions, boards, etcetera, in-

(A copy of the N. C. MedPac report, filed with the appropriate supervisory office is available for purchase from the Superintendent of Documents, United States Government Printing Office, Washington, D. C. 20402.)

a motion that the slate as presented to you be accepted by acclamation.

DR. GEORGE W. PASCHAL: So moved.

(The motion was severally seconded from the floor.)

All those in favor please say "aye"; opposed "no."

The motion carries. The slate is elected.

SPEAKER DAVIS: I think you also recall that the bylaws provide that the Nominating Committee will also circulate to you as voting delegates of this House at least thirty days in advance of our session a list of nominations for committee members of the Society and I'll ask at this time Dr. Elliott Dixon to come forward and place these nominations before you.

DR. J. ELLIOTT DIXON (Chairman, Nominating Committee): Mr. Speaker, Members of the House of Delegates:

We present to you the following names for nomination:

North Carolina Board of Medical Examiners, six year terms:

David S. Citron of Charlotte; James Jerome Pence of Wilmington; and Jack Powell of Asheville.

AMA DELEGATES:

John Glasson of Durham; Donald Koonce of Wilmington.

AMA Alternate Delegates:

James E. Davis of Durham; Louis Shaffner of Winston-Salem.

Medical Care Commission, four year term:

Hugh F. McManus of Raleigh.

Editorial Board, *North Carolina Medical Journal*, four year terms:

George Johnson of Chapel Hill;

Robert W. Prichard, of Winston-Salem.

Board of Directors of North Carolina Blue Cross Blue Shield, three year terms:

Roy S. Bigham, Jr., of Charlotte;

James E. Davis of Durham.

Retirement Savings Plan Committee, three year terms:

A. Hewitt Rose, Jr., of Raleigh;

George W. James of Winston-Salem.

Committee on Blue Shield, three year terms:

Gloria Graham of Wilson;

Melvin F. Eyerman of Lincolnnton;

Carl Warren of Charlotte;

Thomas Fox, Jr., of Charlotte;

Robert M. Gay of Greensboro;

Angus McBryde of Charlotte;

Victor G. Herring of Tarboro;

R. Bertram Williams of Wilmington;

Irvin P. Plaisance of Asheville.

Thank you.

SPEAKER DAVIS: Thank you, Dr. Dixon.

These names have now officially been placed in nomination and the floor is open to other nominations.

(The Speaker called for nominations from the floor for each of the positions listed by the committee on Nominations without a response from the floor.)

May I have a motion then?

DR. DIXON: I move that the nominations be closed and that the slate as submitted be elected.

DR. CHARLES W. STYRON: Second.

SPEAKER DAVIS: Those favoring this motion please say "aye"; opposed "no."

This slate is elected.

Thank you, very much, Dr. Dixon.

I would like to remind the House what a time consuming and difficult job the Nominating Committee has done. I think you are aware of the fact that it excludes the members of this committee from any other position within the Society. It requires a great deal of time and conscientious thought.

We appreciate very much the work your committee has done, Dr. Dixon.

VICE SPEAKER CARR: The next order of business is the report of the Committee on Constitution and Bylaws. In your packets this concerns Reports "M", "P", "Q" and "R" in case you want to refer to them.

Dr. Henry Carr, your newly elected Vice Speaker is also Chairman of the Committee on Constitution and Bylaws. I present him to you at this time for action on his report, or various parts of it.

CONSTITUTION AND BYLAWS

DR. HENRY J. CARR [Chairman, Committee on Constitution and Bylaws]: Mr. Speaker, President Gahert, Members of the House of Delegates:

Report "M" is the first item of business today.

REPORT M

Subject: Proposed Change in The Constitution
Referred To: Reference Committee I

At the 1973 House of Delegates, the following proposed Constitution change was accepted by a majority of the House of Delegate members. Final action on the Constitution change will be made by the 1974 House of Delegates.

ARTICLE IV, Section 7, page 4 of the Constitution regarding student members, the first sentence now reads as follows:

"Any student who is regularly enrolled as a candidate for the degree of Doctor of Medicine in a School in the State of North Carolina and who is an active member of his local Student American Medical Association Chapter shall be eligible for Student Membership."

The proposed change would delete the phrase "and who is an active member of his local Student American Medical Association Chapter"——

The new first sentence would then read as follows:

"Any student who is regularly enrolled as a candidate for the degree of Doctor of Medicine in a school in the State of North Carolina shall be eligible for Student Membership."

The remainder of Section 7 of ARTICLE IV of the Constitution, page 4, would remain unaltered.

The Committee on Constitution and Bylaws recommends this change.

The Committee on Constitution and Bylaws recommends this change, and final action on this proposed constitutional change can be made today.

VICE SPEAKER CARR: You have heard the report of the committee on this proposed change in the constitution. It was received by you last year for consideration. It is now in order that it be approved or disapproved. Ratification will take two-thirds of the members present, or delegates registered.

DR. LOUIS SHAFFNER: Mr. Speaker, I move it be approved.

[The motion was seconded from the floor.]

Any further discussion of this constitutional amendment proposal?

All of those who approve, or are in approval of this report of the constitutional amendment, say "aye"; all opposed "no."

I rule two-thirds carries the amendment and it is approved.

DR. HENRY CARR: Reports "P", "Q" and "R" pertain to constitution and bylaws changes that are submitted to this House of Delegates for consideration.

Report "Q" regards a constitution or bylaws change regarding compulsory continuing education as a requirement for membership in the Society.

This proposed change was submitted as a constitutional change. However, this could be made a bylaws change rather than a constitutional change and therefore could become effective at this annual meeting rather than waiting for the 1975 annual meeting if it is made a constitutional change.

Constitutional changes must wait over for one year for final action and bylaw changes can become effective the same year, laying on the table for one day and receiving an approval vote.

The bylaws change would be to add the sentence as previously proposed as a constitutional change, to Chapter I, Membership, of the bylaws, page 13, making a new section 5 with the proposed sentence. This suggestion is at the discretion of the House of Delegates.

VICE SPEAKER CARR: Since the last one involves change of status, a proposed constitutional change to bylaws change, I will take it up first as it requires decision whether it goes to a Reference Committee as a bylaws change or as a constitutional change.

DR. SHAFFNER: I move that this proposed change be considered as a bylaws change and so submit it to the Reference Committee.

[The motion was severally seconded from the floor.]
No further discussion.

All those in favor of this motion say "aye"; all opposed "no."

[The motion carried.]

You have heard the other two plus this one which as I understand for bylaws change, and will be referred to Reference Committee I.

DR. J. BENJAMIN WARREN: I move that they be accepted for consideration by this House.

The motion was seconded from the floor.]

Any discussion?

All those in favor say "aye"; all opposed "no."

[They have been accepted for consideration and I will now refer them to Reference Committee I.

REPORT P

Subject: Proposed Changes in the Constitution and Bylaws

Referred To: Reference Committee No. 1.

The May 5, 1974, meeting of the Executive Council considered and approved the following proposed changes in the Constitution and Bylaws submitted by the Committee on Constitution and Bylaws, to be submitted to the House of Delegates.

PROPOSED CHANGES IN THE CONSTITUTION AND BYLAWS

Chapter IV—House of Delegates: Chapter IV, Section 2, page 16, line 3, now reads: "A list of such delegates shall be certified officially by the secretary of each component county medical society or in the case

of student delegates by the Chief Executive Officer (or his designee) of each medical school in the State of North Carolina, to the Executive Director of The Society on forms furnished by the Secretary of The Society, who shall issue an official certificate to each delegate."

The proposal is to delete the phrase, "or in the case of student delegates by the Chief Executive Officer (or his designee) of each medical school in the State of North Carolina," and insert after the sentence ending "who shall issue an official certificate to each delegate," on line 8, the following sentences: "In the case of student delegates, the student members of The Society at each medical school in the State of North Carolina shall hold an election on or before December one of each year for the purpose of electing delegates and alternate delegates to the House of Delegates. This election and these delegates and alternate delegates shall be certified by the Chief Executive Officer (or his designee) of each medical school in the State of North Carolina to the Executive Director of The Society in the same manner as provided above for reporting component county medical society delegates. An official certificate shall be issued to each student delegate by the Secretary of The Society."

The remainder of the paragraph would continue as is for the next two sentences (lines 8 through 15). In lines 15 through 17 which now reads: "Every delegate shall be a voting member of The Society and a component county medical or hyphenated society or Student American Medical Association Chapter," delete the phrase, "Student American Medical Association Chapter," and insert the phrase "student member of The Society."

It would then read as follows:

"A list of such delegates shall be certified officially by the Secretary of each component county medical society to the Executive Director of The Society on forms furnished by the Secretary of The Society, who shall issue an official certificate to each delegate. In the case of student delegates, the student members of The Society at each medical school in the State of North Carolina shall hold an election on or before December one of each year for the purpose of electing delegates and alternate delegates to the House of Delegates. This election and these delegates and alternate delegates shall be certified by the Chief Executive Officer (or his designee) of each medical school in the State of North Carolina to the Executive Director of The Society in the same manner as provided above for reporting component county medical society delegates. An official certificate shall be issued to each student delegate by the Secretary of The Society. In the event that the regular delegate is unable to attend, he shall endorse his certificate in favor of his alternate delegate. If neither the delegate nor the alternate delegate is able to attend the meeting of the House of Delegates, the delegate may designate some other member of his society or hyphenated society, or in the case of the Student delegates, the delegate may designate some other student member from his medical school, to attend the sessions of the House of Delegates. Every delegate shall be a voting member of The Society and a component county medical society or hyphenated society or student member of The Society."

II. Chapter XI—Sections: Chapter XI, Section 1, page 54, line 18, now reads: "The following Sections

shall constitute the regular scientific program: Surgery, Internal Medicine, Obstetrics and Gynecology, Public Health and Education, Pediatrics, Ophthalmology and Otolaryngology, Family Physicians, Neurology and Psychiatry, Radiology, Pathology, Anesthesiology, Orthopaedics, Student Member, Dermatology and Urology."

The proposal is to delete the "and" between Ophthalmology and Otolaryngology and inserting a comma in lieu thereof; delete the "and" between Dermatology and Urology, and to insert after "Neurological Surgery" and "Urology."

The sentence would then read as follows:

"The following Sections shall constitute the regular scientific program: Surgery, Internal Medicine, Obstetrics and Gynecology, Public Health and Education, Pediatrics, Ophthalmology, Otolaryngology, Family Physicians, Neurology and Psychiatry, Radiology, Pathology, Anesthesiology, Orthopaedics, Student Member, Dermatology, Urology, and Neurological Surgery."

III. Article IV—Membership of The Society: Article IV, Section 6, page 3, line 16, now reads: "Intern-Resident Training Members: Physicians who are in training in hospitals in the State of North Carolina, which are accredited by the Joint Accreditation Commission on Hospitals for the continuing education of interns or residents licensed to practice in North Carolina may be admitted to membership in The Society without becoming a member of a component county society for and during the period of time in which they are engaged in such training."

The proposal is to change "in the State of North Carolina" to "in the United States" and inserting the phrase "and certify their intention, to the best of their knowledge at that time, to practice medicine in North Carolina," after the phrase "licensed to practice in North Carolina" and before the phrase "may be admitted to membership. . . ."

The first sentence of Section 6 would then read as follows:

"Intern-Resident Training Members: Physicians who are in training in hospitals in the United States, which are accredited by the Joint Accreditation Commission on Hospitals for the continuing education of interns or residents and who are licensed to practice in North Carolina and certify their intention, to the best of their knowledge at that time, to practice medicine in North Carolina, may be admitted to membership in The Society without becoming a member of a component county medical society for and during the period of time in which they are engaged in such training."

REPORT Q

Subject: Constitution and Bylaws Change Regarding Compulsory Continuing Education as a Requirement for Membership in the Society

Referred to: Reference Committee I

The May 5, 1974, meeting of the Executive Council discussed the problem of implementing a change in the Constitution in regard to the compulsory continuing education as a requirement for membership in the Society approved by the House of Delegates in 1973. The Chairman of Committee on Constitution and Bylaws indicated that it had not been possible for the Committee to meet on this subject but that he had some tentative Constitution and Bylaw wording regarding the

compulsory continuing education as a requirement for membership for consideration by the House of Delegates in case they want to take action on this subject at this Annual Meeting.

The suggested wording, by adding a sentence in the Constitution under the Section on Membership of the Society, is as follows:

"Completion and certification of a program of continuing medical education on a periodic basis by the members of the Society as specified by the House of Delegates shall be a requirement for continued membership."

The Executive Council passed a motion to the effect that this part of the report of the Chairman of the Committee on Constitution and Bylaws be accepted in principle with the wording to come from the Committee.

This wording was suggested and approved by the Executive Council, but at this writing has not officially been considered by the Committee on Constitution and Bylaws. It is anticipated, however, that this wording would be approved by the Committee.

Upon introduction of this Report Q before the first meeting of the House of Delegates on Sunday, May 19, 1974, the House of Delegates approved making the amendment a bylaw change instead of a constitution change by adding the above proposed sentence to Chapter I, Membership, as a new Section 5 with the Proposed sentence becoming the new Section 5 on page 1

REPORT R

Subject: Proposed Change in the Constitution and Bylaws

Referred to: Reference Committee No. I

The May 5, 1974, meeting of the Executive Council approved a recommendation from the Chairman of the Annual Convention Commission that the Committee on Memorial Services be dissolved and that the duties of the Committee be assumed by the Committee on Medicine and Religion, and that the Committee on Constitution and Bylaws prepare the amendment to the Bylaws to effect the elimination of the Committee on Memorial Services.

The Committee on Constitution and Bylaws in conformity with this request therefore recommends that this can be accomplished by deleting the phrase, Committee on Memorial Services in Section 2, page 35, Chapter 10—Committees, in section on Bylaws and also by deleting the section on Committee on Memorial Services on page 37, Section 6, Chapter 10—Committees. The whole paragraph that forms Section 6 shall be deleted and the other sections will be numbered appropriately after that with the next printing of the Constitution and Bylaws.

SPEAKER DAVIS: Thank you, Drs. Carr, you new Speaker and Vice Speaker! They certainly work together well and I'm certain they will in the years to come.

Just a word about Reference Committees. These items will, of course, be brought up by the committee. The floor will be open for discussion by anyone, any member of the Society, whether he be delegate or not and anyone interested in testifying as to any of these resolutions is welcome and even non-members of the Society, at the discretion of the Chairman, if they are

elt to have input as a resource person, will be allowed to speak.

These reports as you have seen have been culled out of the reports of the three sessions of the Executive Council and since this House has the authority to accept or reject the actions of the Executive Council, you are the ultimate authority of this Medical Society. All of the reports emanating from the Council must be presented to you.

I will now recognize Dr. Gilbert, Chairman of the Executive Council of course, to submit the other reports from the Council, those not relating to changes in constitution and bylaws.

REPORTS OF THE EXECUTIVE COUNCIL

PRESIDENT GILBERT: Each of you have received your packets, summaries of the actions of the Executive Council at its sessions on September 30th, 1973; February 3rd, 1974; and, May 5th, 1974.

These three summaries represent actions by the Executive Council which it was felt did not require special reports, but which are submitted in summary form for your consideration and hopefully your approval.

You have also in your delegate packet Reports "A" through "R" which originated from actions of the Council at these three meetings. There is no Report "L" because that letter was accidentally overlooked in the printing of the reports.

The Chairman of the Committee on Constitution and Bylaws has already reported on "M," "P," "Q" and "R."

I, therefore, move that these lettered reports as printed, with the exception of "L," "M," "P," "Q" and

"R" be received at this time for consideration by the House of Delegates and referral to the Reference Committee as indicated, without being read at this time or further identified.

[The motion was severally seconded from the floor.]

SPEAKER DAVIS: The motion was to refer all of the other reports Dr. Gilbert has mentioned. Questions regarding these reports are in order, debate is not, but as I've indicated open debate will be available in the Reference Committees. These committees consisting as you see of three delegates will then bring in a recommendation to the House on Tuesday.

Again, if you have not found satisfaction in your discussion at the Reference Committee, the floor will be available for further discussion and a vote at that time.

So, we are then back to the motion to refer the reports as listed by Dr. Gilbert.

Any discussion on this?

[No response]

Those favoring this motion for referral, please say "aye"; opposed "no."

They are referred as indicated and we will not read the specific Reference Committee numbers.

REPORT A

Subject: The Annual Budget Estimates for 1974
Referred to: Reference Committee No. 1

The Executive Council, at its September 30, 1973 meeting, considered the proposed budget for 1974 as recommended by the Committee on Finance.

On motion duly made and seconded, the budget estimates for 1974 were adopted by the Council.

The Budget Estimates for 1974 are as follows:

BUDGET ESTIMATES

January 1, 1974 to December 31, 1974

RECEIPTS: (ESTIMATED)	1973	1974
Estimated balance January 1, 1974.....	NIL	NIL
Annual Dues, paying members.....	\$520,000	\$376,000
Sales—Rosters, Journals	3,500	5,600
Revenue Unexpected	3,000	4,500
Technical Exhibits	10,000	10,560
Journal Net Advertisement—Local.....	10,000	10,000
Journal Net Advertisement—National.....	35,000	35,000
**AMA Remittance 1% of dues processed—plus interest.....	3,700	7,500
MEDPAC Remittance 1% of dues processed.....	220	220
Rental Income (New Headquarters Facility).....	49,936	50,936
Interest Income—Operating Funds.....	—0—	6,000
	<hr/> \$635,356	<hr/> \$506,316
EXPENDITURES: (ESTIMATED)		
Schedule A	\$205,140	\$228,910
Schedule B	82,252	86,425
Schedule C	34,750	34,790
Schedule D	14,160	18,100
Schedule E	8,260	8,610
Schedule F	22,060	21,490
Schedule G	43,609	52,541
Schedule M	225,125	55,450
	<hr/> \$635,356	<hr/> \$506,316

to be appropriated to Secretarial Budget A-6.

	1973	1974
EXCESS OF RECEIPTS OVER EXPENDITURES	—0—	—0—
EXCESS OF EXPENDITURES OVER RECEIPTS.....	—0—	—0—
RESERVES: (Estimated Cash Reserves—\$60,000)		
SUBMITTED TO COMMITTEE ON FINANCE.....	September 16, 1973	
SUBMITTED TO EXECUTIVE COUNCIL FOR APPROVAL.....	September 30, 1973	
SUBMITTED TO HOUSE OF DELGATES FOR APPROVAL.....	May 19, 1974	

A. EXECUTIVE BUDGET

A- 1 President, expense of (travel & communications)	\$ 7,000	\$ 8,000
A- 2 President's secretarial assistance.....	5,000	4,000
A- 3 Secretary, travel of	1,000	1,000
A- 4 Executive Director-Treasurer, salary of	24,000	26,160
A- 5 Executive Director-Treasurer, travel of	6,000	6,500
A- 6 Executive Office, Secretarial & Clerical Assts.**	45,000	53,000
A- 7 Executive Office, equipment-replacements.....	4,000	4,000
A- 8 Executive Office, expense of (communications, printing, and supplies, repairs & replacements of expendables).....	18,000	20,000
A- 9 Bonding (in effect to 1975).....	—0—	—0—
A-10 Audit (Quarterly & Annual).....	2,000	2,300
A-11 Taxes (salary tax).....	6,440	7,600
A-12 Insurance: fire, liability & compensation.....	2,200	2,200
A-13 Membership Record, Acctg., IBM Machine Rental, Forms.....	8,600	10,400
A-14 Publications, reports & executive aids.....	300	300
A-15 Assistant Executive Director, salary of.....	17,200	18,700
A-16 Assistant Executive Director, travel of.....	3,000	3,500
A-17 Assistant to Executive Director, salary of.....	12,900	14,500
A-22 Controller, salary of.....	15,400	16,600
A-23 Field Representative, salary of.....	12,500	13,500
A-24 Field Representative, salary of.....	9,600	10,600
A-25 Field Representatives, travel of*.....	5,000	6,000
	<u>\$205,140</u>	<u>\$228,900</u>

B. JOURNAL BUDGET

B- 1 Journal, printing and mailing.....	\$ 59,800	\$ 62,000
B- 3 Editor, salary of.....	B-11†	B-11
B- 4 Assistant Editor, salary.....	B-11†	B-11
B- 5 Editorial Office, expense of (12 months rent, communications, printing and supplies, repairs and replacements).....	850	850
B- 6 Journal Business Manager's Office expense of (12 months communications, printing and supplies, repairs, and replacements).....	1,000	950
B- 7 Business Manager's Office, equipment for.....	100	100
B- 8 Journal, travel for (Local and National)	200	100
B- 9 Taxes (salary tax)	1,052	1,200
B-10 Sales tax on Journal subscriptions and Roster Sales.....	2,200	2,400
B-11 Journal Salaries	17,050	18,800
B-13 Advertising Secretary, salary of.....	B-11†	B-11
	<u>\$ 82,252</u>	<u>\$ 86,400</u>

C. INTRA-FUNCTIONAL ACTIVITY BUDGET

C- 1 Executive Council expense of and travel of Councilors including district travel	\$ 4,600	\$ 4,500
C- 2 Publication of Executive Council Minutes, Transactions, Annual Reports.....	6,500	5,500
C- 3 Legislative Committee, expense of (Local and National activity).....	5,000	6,500
C- 4 Maternal Health Committee, expense of (secretarial, communications, printing and supplies).....	600	300
C- 5 Committee on Drug Abuse	1,000	200
C- 6 Committee on Arrangements	C-11	C-11
C- 7 Committee on Scientific Exhibits, expense of (including \$200 for Scientific Exhibit Awards and \$200 for Student Scientific Exhibit Award)—Committee		

* Basis: Real for personal maintenance and travel at 15¢ per mile and or common carrier rate and for official purposes.

** Any revenue derived from collection efforts related to American Medical Association dues and processing of same shall accrue to this item of Budget.

† Transferred to B-11

	1973	1974
on Audio-Visual Programs transferred to separate line item C-61.....	\$ 1,225	\$ 1,220
8 Committee on Mental Health	400	400
9 Committee on Mediation	400	500
10 Committee on Chronic Illness, TB & Heart Disease.....	400	C-11
11 Committees in general, expense of (including committees under \$100 allocations)	4,500	4,500
12 Committee on Nominations	C-11	C-11
13 Committee on Occupational & Environmental Health.....	C-11	200
14 Committee on Professional Insurance	C-11	C-11
15 Committee on Relative Value Studies.....	600	600
16 Committee on Negotiations	C-11	discontinued
17 Committee on Student AMA [Section & Transportation & Delegate to SAMA one each Medical School Chapter (3)].....	1,060	2,000
18 Committee on Disaster Emergency Medical Care.....	600	600
19 Committee on Industrial Commission	C-11	C-11
20 Committee on Constitution and Bylaws.....	500	500
21 Committee on Medical-Legal	C-11	C-11
22 Committee Advisory to N. C. Department of Motor Vehicles.....	C-11	C-11
23 Committee on Cancer	C-11	C-11
24 Committee on Anesthesia Study.....	365	320
25 Committee on Child Health & Infectious Disease.....	C-11	C-11
26 Committee on Blue Shield	C-11	C-11
27 Committee on Hospital and Professional Relations.....	C-11	C-11
28 Committee on Social Services Program.....	C-11	C-11
29 Committee on Memorial Services (Necrology).....	C-11	C-11
30 Insurance Industry Committee.....	800	800
31 Committee on Community Medical Care, sponsorship of 4-H Health activity for trip to National 4-H Club for State Health Winner, and "Today's Health" subscription to 4-H Health winners; Dues Rural Health Safety Council; Miscellaneous expense	500	500
32 Committee on Retirement Savings Plan.....	C-11	C-11
34 Committee on General Sessions Program (Scientific Works).....	C-11	1,500
36 Committee on Marriage Counselling & Family Life Education.....	300	500
37 Committee on Medicine and Religion.....	350	350
38 Committee on AMA-ERF (Chairmanship includes Auxiliary under item D-3).....	C-11	C-11
39 Committee on Credentials	C-11	C-11
40 Committee on Scientific Awards	C-11	C-11
41 Committee on Physical and Vocational Rehabilitation.....	C-11	C-11
42 Committee on Eye Care and Eye Bank.....	C-11	C-11
43 Committee on CHAMPUS	C-11	discontinued
45 Council on Review & Development.....	C-11	C-11
46 Committee on Finance	C-11	C-11
48 Committee on Medicare	200	C-11
49 Committee on Medical Education	1,000	1,000
50 Committee on Comprehensive Health Service Planning.....	250	C-11
51 Committee on Medical Aspects of Sports.....	1,000	1,000
52 Committee on Association of Professions.....	C-11	C-11
53 Committee on Physicians on Nursing.....	200	200
54 Committee Liaison to N. C. Pharmaceutical Association.....	C-11	C-11
55 Committee on Personnel & Headquarters Operation.....	C-11	C-11
56 President's Communications Program (Newsletter).....	1,200	transferred to item D-5
57 Advisory Committee on the Crippled Children's Program.....	C-11	C-11
58 Committee on Peer Review.....	200	200
59 Committee on Health Care Delivery.....	1,000	750
60 Committee on Archives of History-NCMS.....	C-11	C-11
61 Committee on Audio-Visual Programs (Combined with item C-7 in 1973).....	combined with C-7	150
	\$ 34,750	\$ 34,790

EXTRA-FUNCTIONAL ACTIVITY BUDGET

11 Delegates to AMA, expense of (8 including alternates to each Annual and Clinical Session)	\$ 9,700	\$ 11,100
12 Conference Dues	200	250

	1973	1974
D- 3 Woman's Auxiliary (contribution to entertainment, travel to National Auxiliary for 2 and productions).....	\$ 4,260	\$ 5,400
D- 5 President's Communication Program (Newsletter) (transferred from item C-56).....	See C-56	1,300
	\$ 14,160	\$ 18,100
E. PUBLIC RELATIONS BUDGET		
E- 3 Committee Chairman, out of State travel.....	\$ 500	\$ 500
E- 9 Audio-Visual depiction, photography, radio-motion pictures, production, distribution and printing, purchase of films, etc.....	—0—	100
E-10 Educational distribution; reprints, periodicals, press materials, pamphlets, and dodgers for educational purposes; production, distribution and printing, binding, stuffing and mailing.....	500	300
E-11 News and press releases, production and printing of.....	200	200
E-12 Public Relations Bulletin, production and printing of.....	3,500	3,800
E-13 State High School Science Fair Program, Award for.....	160	100
E-14 Exhibits and Displays: Purchase, rental, production, fabrication and transportation of	350	500
E-15 Conference for Medical Leadership.....	1,500	1,500
E-17 <i>Today's Health</i> Magazine Subscriptions.....	850	800
E-18 Collateral Public Relations with other committees.....	500	500
E-19 N. C. Rescue Squad First Aid Trophies.....	200	200
	\$ 8,260	\$ 8,600
F. ANNUAL SESSIONS (120th) CONVENTION BUDGET		
F- 1 Program, Production of.....	\$ 2,000	\$ 2,000
F- 2 Hotel and Auditorium expense.....	4,700	5,000
F- 3 Publicity promotion, expense of (reporters and expense).....	600	600
F- 4 Entertainment (general involving personnel).....	1,200	1,200
F- 5 Orchestra and Floor entertainment.....	2,500	2,500
F- 6 Guest Speakers expense and or honorarium.....	900	500
F- 8 Electric Amplification, operators, installations and screening auditorium.....	—0—	—0—
F- 9 Booth installations, supplies, expense signs (Scientific and Technical) including exhibit expense & promotion.....	4,500	4,500
F-10 Projection, expense of (service rentals).....	1,300	800
F-11 Badges (members, guests, exhibitors, auxiliary).....	250	200
F-12 Reporting Service for Transactions—(House of Delegates, General Sessions and Reference Committees)	2,500	2,500
F-13 Rental, extra facilities, trucks for sections and or exhibits.....	200	200
F-14 Exhibitors entertainment	850	800
F-15 Banquet expense	200	200
F-16 Police Security	360	300
	\$ 22,060	\$ 21,500
G. MISCELLANEOUS BUDGET		
G- 1 Legal Counsel, retainer fees for.....	\$ 11,300	\$ 16,300
G- 2 Reporting, Executive Council Meetings.....	2,000	2,000
G- 3 Fifty Year Club Pins and Certificates, and President's Jewel.....	300	300
G- 4 Contingency and Emergency.....	4,174	3,500
G- 5 Retirement System for Society Employees.....	19,175	21,000
G- 6 Advalorem Taxes (Personal Property).....	960	900
G- 7 Association of Professions.....	200	200
G-10 Commissioners, expense of.....	1,500	1,500
G-11 Executive Committee, expense of.....	300	300
G-12 Officers, expense of.....	2,000	2,000
G-13 Travel and Maintenance, expense of essential Headquarters Staff for out-of-state meetings and in-state conferences.....	1,700	2,000
G-14 NCMS Headquarters Staff Hospitalization and Insurance Coverage.....	charged to G-4	2,000
	\$ 43,609	\$ 52,500

M. HEADQUARTERS FACILITY BUDGET

1973

1974

Capital Investments

M- 1 Application to Mortgage Payments—estimated available.....	\$162,261	—0—
M- 3 Mortgage Payable on Greenfield Property @ 1/5 of \$13,000 plus 7% interest on unpaid balance of \$5,200 (\$2,600 plus \$364 interest).....	2,964	—0—
M- 4 Estimated Interest Cost on Mortgage (\$100,000 @ 7%).....	7,000	—0—
Sub-total	\$172,225	—0—

Operating Costs

M- 5 Utilities	\$ 13,800	\$ 15,000
M- 6 Insurance	1,700	1,750
M- 7 Taxes (Real Property).....	16,700	16,200
M- 8 Water	500	500
M- 9 Janitorial Services	15,000	13,500
M-10 Grounds Maintenance	1,000	1,500
M-11 Building Repairs and Maintenance.....	1,200	4,000
M-12 Heating A/C Repairs & Maintenance, Elevator Maintenance.....	3,000	3,000
	\$225,125	\$ 55,450

REPORT B

Subject: Report of the ad hoc Committee to Study and Recommend a Salary or Increase in Allowances for the President

Referred to: Reference Committee No. I

The ad hoc Committee to Study and Recommend a Salary or Increase in Allowances for the President was appointed by President John Glasson, M.D., at the direction of the May 1973 meeting of the House of Delegates. This was the result of House approval of Reference Committee II's substitute resolution for Resolution No. 3 (1973) introduced by Pitt County Medical Society. The substitute resolution resolved "that a method be made to increase the allowances for the President of the Society" and "that this matter be referred to an ad hoc committee appointed by the President for further study and recommendation."

The committee sent a questionnaire to each State Medical Society. The information received covered (1) the number of full-time and part-time employees; (2) size of annual budget; (3) does the President receive salary, and if so how much; (4) does the President receive pay for outside secretarial and/or office expenses, either on a fixed or reimbursable basis; and (5) does the President receive travel expenses and if so is he paid on a fixed annual or monthly allowance or on an actual reimbursement basis?

It was found that of the 44 response, N. C. is among 12 states responding with a budget in excess of \$500,000. Only eight percent of the states pay their President compensation, ranging from \$1,000 to \$10,000. Ten of the states provide funds for secretarial help and nine states pay for secretarial help on a reimbursable basis. Only four states do not pay for travel expenses.

The Charter of the North Carolina Medical Society does not prohibit it from paying the President for services rendered, however such payment would require that he come under the same provisions of any other its employees. The recipient of funds would be required to treat such monies as income. The Committee felt that with the coverage for travel and costs incurred plus the provision for secretarial help that the

Society actually exceeds the \$10,000 salary provided by some states.

The Committee agreed that the President should receive a generous allowance for expenses incurred, but that a definite salary should not be provided. Based on these and other considerations the Committee:

RECOMMENDED THAT THE SOCIETY CONTINUE TO PAY REIMBURSABLE EXPENSES ATTENDANT TO THE PRESIDENT INCLUDING NECESSARY TRAVEL, HOUSING, FOOD, COMMUNICATIONS, AND OUT-OF-POCKET SECRETARIAL EXPENSES; AND THAT IN ADDITION, THE SOCIETY PAY A PER DIEM AT THE RATE OF \$25 PER DAY FOR DAYS OR PARTS OF DAYS SPENT BY THE PRESIDENT OUTSIDE OF THE HOME TOWN ON SOCIETY BUSINESS.

AND FURTHER RECOMMENDED IN ALLEVIATING THE BURDEN OF ASSUMING THE PRESIDENCY THAT THE PRESIDENT-ELECT AND THE IMMEDIATE PAST PRESIDENT BE REIMBURSED FOR THEIR TRAVEL AND LIVING EXPENSES WHEN BY VIRTUE OF THEIR OFFICE THEY ARE INVOLVED IN OFFICIAL MEDICAL SOCIETY FUNCTIONS.

It was estimated that the cost incidental to the implementation of the first recommendation will be about \$2,500 and of the second, about \$1,500.

REPORT C

Subject: Request that the Section on Ophthalmology and Otolaryngology be divided into a Section on Ophthalmology and a Section on Otolaryngology

Referred to: Reference Committee I

A May 30, 1973, letter from Lee A. Clark, Jr., M.D., 1973 Chairman of the Section on Ophthalmology and Otolaryngology advised President George Gilbert that the Section had voted to split into separate sections and requested the creation of a Section on Ophthalmology and a Section on Otolaryngology. The letter also requested that the old Section on Ophthalmology and Otolaryngology be discontinued.

At its September 30, 1973, meeting, the Executive

Council considered and recommended to the House of Delegates approval of the request from the Section on Ophthalmology and Otolaryngology.

REPORT D

Subject: Guidelines for a Medical Director in a Long-Term Care Facility

Referred to: Reference Committee No. II

The September 30, 1973, meeting of the Executive Council approved a recommendation of the Committee on Chronic Illness that the North Carolina Medical Society endorse the principle that long-term care facilities in North Carolina employ the services of a physician to serve as Medical Director. It also recommended and the Council approved, that the Society endorse the "Guidelines for a Medical Director in a Long-Term Care Facility," as adopted by the American Medical Association, as follows:

1. Assist in arranging for continuous physician coverage for medical emergencies and in developing procedures for emergency treatment of patients.
2. Participate in development of a system providing a medical care plan for each patient, which covers medications, nursing care, restorative services, diet, and other services, and, if appropriate, a plan for discharge.
3. Be the medical representative of the facility in the community.
4. Develop liaison with attending staff physicians in efforts to ensure effective medical care.
5. In the absence of an organized medical staff, be responsible for the development of written bylaws, rules and regulations applicable to each physician attending patients in the facility.
6. If there is an organized medical staff, be a member, attend meetings and help assure adherence to medical staff bylaws, rules and regulations.
7. Participate in developing written policies governing the medical, nursing and related health services provided in the facility.
8. Participate in developing patient admission and discharge policies.
9. Participate in an effective program of long-term care review.
10. Be available for consultation in the development and maintenance of an adequate medical record system.
11. Advise the administrator as to the adequacy of the facility's patient care services and medical equipment.
12. Be available for consultation with the administrator and the director of nursing in evaluating the adequacy of the nursing staff and the facility to meet the psychosocial as well as the medical and physical needs of patients.
13. Be available for consultation and participation in in-service training programs.
14. Advise the administration on employee health policies.
15. Be knowledgeable concerning policies and programs of public health agencies which may affect patient care programs in the facility.

REPORT E

Subject: Treatment of Tuberculosis Cases and Potential Cases

Referred to: Reference Committee No. II

The September 30, 1973, meeting of the Executive Council voted to approve the recommendation of the Committee on Chronic Illness as follows:

WHEREAS, in calendar year 1972, reports were made to public health authorities of 996 new active cases of tuberculosis with sixty per cent being over the age of 44 years and seventy per cent being male, 13 reactivations of tuberculosis and 113 deaths attributed to tuberculosis in North Carolina, and

WHEREAS, in 1972 North Carolina had the twelfth highest new active tuberculosis case rate in the nation (19.1 per 100,000 population compared to U.S. rate of 15.8 per 100,000) the Committee on Chronic Illness of the North Carolina Medical Society recommends:

- (1) a renewed effort to identify and bring to treatment cases and potential cases of tuberculosis among the population
- (2) that where treatment is indicated every attempt be made to select, with appropriate consultation and laboratory investigation as necessary, an adequate regimen of anti-tuberculosis drug therapy for a minimum of two years of uninterrupted treatment in the case of active or probably active disease
- (3) that the initial phase of treatment of active cases covering the period of possible infectiousness should, in most cases take place in a hospital having the necessary medical, laboratory and supporting facilities for full evaluation and formulation of optimum drug therapy plans
- (4) that responsibility for supervising the carrying out of treatment at home and epidemiological investigation of cases including the reporting of new cases be actively shared with public health authorities.

NOTE: The tuberculin skin test is recommended as the initial screening procedure of choice in tuberculosis casefinding.

REPORT F

Subject: Recommendation that hemophilus influenzae meningitis be made a reportable disease

Referred to: Reference Committee No. II

The September 28, 1973, meeting of the Committee on Child Health and Infectious Diseases discussed the Flu Meningitis problem in the Charlotte area. It was reported that there had been 8-10 cases in the Charlotte area during the year. Following the discussion the Committee recommended:

In the light of its common occurrence and serious complications both in the regard to mortality and permanent brain damage, we feel that we should strongly express the feeling that Hemophilus Influenza Meningitis be named as a reportable disease. This is particularly apropos at the moment in that vaccines may be available in the near future to prevent this disease and a large clinical trial on the vaccine is being performed in Mecklenburg County.

The September 30, 1973 meeting of the Executive Council, approval was voted for approval of the Committee recommendation.

REPORT G

Subject: Change in Dates of Annual Meeting and Survey of the Membership Regarding Choice of May or September

Referred to: Reference Committee No. I

The September 30, 1974, meeting of the Executive Council approved a recommendation of the Committee on Arrangements for approval of September dates for the Annual Meeting beginning in 1975 or as soon thereafter as possible.

However, a following motion passed by the Executive Council instructed that the Executive Director and staff prepare a questionnaire to the membership concerning the question including choice of dates as May opposed to September.

A Survey was mailed to the membership on April 1, 1974, and by April 26, 1974, 1500 responses had been returned to the Headquarters Office.

Pinehurst received more than a four to one vote as the preferred location in contrast to the other cities listed which appear to have adequate facilities at present or holding the Annual Meeting.

An overwhelming majority voted for an Early or Mid May time of year for the Annual Meeting with only slightly over 400 voting in favor of a September meeting time.

A majority of those responding expressed a willingness to pay a registration fee of from \$10 to \$25 at the Annual Meeting if this became necessary, with 903 of those responding indicating a willingness to pay a Registration Fee.

REPORT H

Subject: Compulsory Continuing Education as a Requirement of Membership

Referred to: Reference Committee No. I

The September 30, 1973, Executive Council voted approval of the Committee on Medical Education recommendation for implementation of a program of compulsory continuing education as follows:

(1) that a minimum of fifty hours of continuing education per year be required of each member of the State Society.

(2) that wide latitude be allowed in the manner in which the required time is spent. Attendance at scientific meetings, participation in clinical conferences, perusal of the scientific literature, etcetera, are all recognized as worthwhile forms of continuing education and credit will be given for time so spent.

(3) that each physician keep and submit such records as will enable him to certify each year that he has met the minimum requirement of fifty hours.

(4) that a form for certifying compliance with the above requirement be included with the annual notice of dues sent each physician. This form could then be returned along with payment of dues.

REPORT I

Subject: Resolution Regarding the Delivery of Primary Medical Care for Winston-Salem, N. C. (Resolution 12—1973 Annual Meeting)

Referred to: Reference Committee No. II

Resolution 12 (Annual Meeting 1973) was introduced by the Forsyth County Medical Society on the subject: "Suggested Resolution Regarding the Delivery

of Primary Medical Care for Winston-Salem, North Carolina."

Resolution 12 (A-73) was referred to Reference Committee No. I which recommended that this resolution be referred to the Executive Council for further consideration.

The Executive Council, at its February 3, 1974, meeting in Raleigh, further considered Resolution 12 (A-73) and after a review of suggestions by interested parties recommended the following report to the House of Delegates:

Since the purpose of the original resolution was to assure a study that would aid the Board of Governors of the University in making a realistic recommendation to the Legislature, it would seem that the study which the Board of Governors themselves had done by a Panel of Medical Consultants (September 21, 1973) has accomplished the purpose of the original resolution from Forsyth County.

It was the suggestion of the Executive Council, therefore, that the attention of the House of Delegates and the Membership be called to this study as an authoritative, unbiased, and lucid one which fulfills the intent of the original resolution.

REPORT J

Subject: Request for the Establishment of a Section on Neurological Surgery

Referred to: Reference Committee No. I

A January 25, 1974, letter to President George G. Gilbert from Ira M. Hardy, II, M.D., acting chairman of the newly organized North Carolina Neurosurgical Society, requested that a Section on Neurological Surgery be formed in the North Carolina Medical Society.

As its February 3, 1974, meeting, the Executive Council considered the request and recommended to the House of Delegates approval of the request.

REPORT K

Subject: Proposed Position Paper "Need for More and Better Distributed Primary Care Physicians"

Referred to: Reference Committee No. II

At the February 3, 1974, meeting of the Executive Council, a proposed position paper on "Need for More and Better Distributed Primary Care Physicians" was presented from the Committee on Community Medical Care by Dr. John L. McCain, Commissioner on behalf of Committee Chairman, Dr. J. Kempton Jones.

After considerable discussion, the Executive Council voted to commend the Committee on Community Medical Care for doing an outstanding job and that the proposed position paper be widely publicized to the membership and referred to the House of Delegates at the Annual Meeting in May.

The proposed position paper is as follows.

**NEED FOR MORE AND BETTER DISTRIBUTED
PRIMARY CARE PHYSICIANS IN
NORTH CAROLINA**

**Committee on Community Medical Care,
North Carolina Medical Society**

The North Carolina Medical Society is vitally concerned with every aspect of the medical care of the

people of North Carolina. Of particular concern are the deficiencies in the delivery of primary medical care to the people of North Carolina in rural and less urbanized areas of the state.¹

In keeping with the leadership that has become expected of the North Carolina Medical Society and as evidence that our present medical care system is concerned and responsive, the following position paper has been prepared on the need for more and better distributed primary care physicians. The Committee on Community Medical Care is comprised predominantly of primary care physicians who, by interest and practice characteristics, are knowledgeable of the problems involved.

PROBLEM DESCRIPTION

Distribution

It is desirable that physician services in North Carolina be evenly accessible to the population in all geographic settings in relation to demand. Until now, such accessibility has not been possible because physician distribution, as that of many segments of the population, has been markedly influenced by economic and social conditions and by urban and rural dynamics. Such factors include the prevalence of poverty, age, and accidents, and the availability of communication, transportation, educational, cultural, and recreational resources.² The result has been a dramatically disproportionate concentration of physicians in various population areas.

Primary medical care

Of equal importance is the problem of having the right physician in the right place at the right time. The distribution of physicians by medical specialty is comparable in importance to the total number of physicians and their geographic distribution.

Health care manpower is a special and acute problem in North Carolina, particularly with respect to primary care which includes the full spectrum of basic services needed to maintain and restore health. Primary care services are called for in 80 to 90 percent of all patient needs. Yet the predominance of the effort is focused on the other 10 to 20 percent—training specialists and subspecialists who are increasingly less trained for handling the problems of primary care.²

The modern personal physician considers the expanded health care team and diverse community resources as an extension of himself. This type of team can be the most efficient and flexible means of assuring comprehensive primary health care made available to the rich or poor in rural or urban settings.²

Part of the dilemma of underserved areas is that there has not been an advocate with responsibility for allocating health care manpower for primary and rural health care. Until recently medical schools have not been accountable for producing the numbers and kinds of physicians that society needs. The types of educational programs offered have led to a migration of medical manpower from rural areas to more urban areas where the more sophisticated facilities have been located. Their efforts, quite understandably, have been directed toward developing programs that would attract federal monies available at the time which, unfortunately, were mostly earmarked, until recently, through government designation for other than primary care services.²

Financing rural care is a most difficult problem. Actual cost per unit of service is frequently higher in rural areas, especially if an attempt is made to provide a broad spectrum of health care. Many rural areas are unable to support even a rudimentary public health care system, let alone one directed toward providing comprehensive care. The financial incentives are often inadequate, and discriminatory reimbursement practices by third party payors for rural physicians compound the problem.²

SUPPORTING DATA

Geographic distribution

The geographic distribution of physicians by population in North Carolina is as follows: In rural North Carolina there are 1,737 people to each physician; there are 760 people to each physician in urban North Carolina. In rural North Carolina there are 2.3 times more people per physician than in urban areas of the state.

In the six most populated counties in North Carolina the population physician ratio is 859:1. The population physician ratio is 2,396:1 in the six least populated counties.⁴

Graduating physicians

Between 1958 and 1972 North Carolina had a total of 2,983 physician graduates.⁵ Bowman Gray School of Medicine had 776 (26 percent); Duke University Medical School had 1,226 (41 percent); and the University of North Carolina School of Medicine had 981 (33 percent).

Retention rates

Retention of North Carolina medical school graduates for practice in North Carolina allows three years for placement.⁶ Because of internship, residency, and military obligations, there is frequently a time lag of five to seven years between the time of graduation and establishment in practice. From 1955 to 1964, the number of physicians who graduated from North Carolina medical schools was 1,869; of these, 40 percent had settled in North Carolina as of 1967.

The retention rates for each of the schools are as follows: Bowman Gray School of Medicine—37 percent; Duke University Medical School—29 percent; University of North Carolina School of Medicine—5 percent.

Primary care physicians in North Carolina

Of the 1,869 graduates from North Carolina Medical schools between 1955 and 1964, four hundred and twenty (22 percent) were practicing in North Carolina in the primary medical care specialties by the year 1972. The breakdown from the three schools is as follows: Bowman Gray School of Medicine—22 percent of 49 graduates; Duke University Medical School—13 percent of 782 graduates; University of North Carolina School of Medicine—32 percent of 594 graduates.

Of the 5,964 non-federal physicians practicing in North Carolina in 1971, 45 percent (2,583) were in the primary medical care specialties: 19 percent were in family medicine; 13 percent were in internal medicine; six percent were in pediatrics; and seven percent were in obstetrics-gynecology.⁸

Training programs for primary care specialties in North Carolina

In 1972 there were 703 residents in training in North Carolina, of whom 27 percent were in training in the primary care specialties.⁹

Relationships can be seen between the 45 percent of non-federal physicians practicing in North Carolina in the primary medical care specialties in 1971, the 27 percent of total residents in training in North Carolina in primary medical care specialties in 1972, and the recently adopted AMA goal that at least 50 percent of all medical graduates enter residency training in the primary care specialties in the coming years.

PREVIOUS STUDY REPORTS

The North Carolina Medical Society has long been interested in promoting realistic solutions to meet the problems of medical manpower, as evidenced by two reports in 1972 regarding "Medical Students and Medical Manpower" by the Joint Conference Committee, and the "Recommendations from the Conference on Access to Health Care" by the Public Relations Committee. Recommendations regarding these problems, including the need for more medical school graduates in North Carolina, have been made in the "Report of the Statewide Plan for Medical Education in North Carolina" by a panel of medical consultants to the Board of Governors of the University of North Carolina. The UNC Board of Governors has prepared Recommendations Consistent with the Report of the Panel of Medical Consultants on a Statewide Plan for Medical Education in North Carolina. Separate recommendations have been prepared by the Medical Manpower Commission of the North Carolina State Legislature which call for the graduation of an increased number of physicians in North Carolina and the addition of a second year to the ECU Medical School.

RECOMMENDATIONS

Alleviating maldistribution

The scholarship or loan funds administered through the North Carolina Department of Human Resources to support medical education, with forgiveness of indebtedness if the student ultimately practices for a short length of time in rural areas, should be continued and enlarged.¹⁰

Medical school admission and recruitment criteria should be altered in favor of those factors in the applicant's background which might encourage him to practice in an underserved area. Medical students should be more oriented to the needs of medically deprived areas.¹¹

Admission committees to medical schools should include as full active members independent primary care physicians. Since this service can be very time consuming for a busy practitioner, reimbursement for time spent should be provided.¹²

In the selection criteria for scholarship recipients in the proposed scholarship program for undergraduate medical students, to be implemented by the Board of Governors of UNC for financially disadvantaged students, high priority should be given those applicants who express an interest in entering a primary care specialty and serving in an underserved area.¹³

The Resident Physician-Preceptor Field Training Program for Primary Care-Family Practice Residents, being implemented by the North Carolina Department of Human Resources, should be supported and expanded. This program provides opportunities for primary care residents to receive part of their training in rural communities with selected medical practitioners.¹⁴

The statewide network for decentralization and coordination of medical and health professional education through development of Area Health Education Centers in North Carolina should be encouraged. The decentralization of undergraduate and graduate medical education through the greater use of community hospitals for intern and residency training will also be beneficial.¹⁵

Expansion of transportation and communication capabilities between rural areas and larger medical centers, presently in the planning stage by the Emergency Medical Services Network, should be accomplished, making adequate provision for appropriate reimbursement for medical services to be provided. Such reimbursement will be vital to the success of this program.¹⁵

The enhanced use of allied health professionals to increase the productivity of physicians, particularly those in rural areas, can be a beneficial influence. A program to help accomplish this, although not in itself a substitute for increased production of primary care physicians, is being implemented by the North Carolina Medical Society.¹⁶

The proposal to establish a network of primary medical care clinics throughout the state, as a cooperative endeavor between the community and the state, with supervision and backup by physicians and hospitals in nearby towns and cities, is an experimental program that deserves continuing support and guidance by the North Carolina Medical Society. The support of backup physician coverage will be vital to its success.¹⁷

Consideration should be given, with assistance from the interested agencies available, to expanding the function of the North Carolina Medical Society's Physician Placement Service to include development of demographic profile data on communities seeking a physician and active contact with physicians on behalf of such communities.¹⁸

New physicians moving into underserved areas should be allowed fee reimbursement for services provided, similar to those in other areas, and should not be limited for reimbursement to previously existing regional, prevailing fee schedules. These new reimbursement allowances should be included in determining prevailing fee schedules.¹⁹

Efforts such as job fairs, similar to the 1973 Student Physician Community Fair by the North Carolina Academy of Family Physicians, to bring physicians and rural leaders together should be supported and encouraged. Advance planning by representatives of parties involved and widespread publicity are important for the success of these programs.^{16, 20}

Correlating medical education with function

In the development of new curricula for medical students, further relevance should be sought by increased emphasis on performance criteria including task analysis and team concepts.¹¹ There should be greater interrelationship of training programs for medical and allied health professionals. Core courses in geographic proximity

mity of the training programs to areas of need, as that envisioned in the expanded AHEC program, is one way to accomplish this.¹¹

The professional associations should provide programs to interest medical students in selecting primary care specialty, such as that provided by the North Carolina Family Practice Club of Medical Students.²⁰

Attractive credit-bearing electives in community primary medical care, using practicing physician preceptors (not limited to the AHEC affiliated community hospitals mentioned in the preceding recommendation) should be developed so that, as a goal, 25 per cent of senior medical students' available elective time can be spent in rotations off university medical center campuses. Full reimbursement of student translocation expenses and appropriate preceptor reimbursement should be provided. Utilization of model medical practices, with physician preceptors who successfully demonstrate for medical students how underserved areas can effectively be served, should be given highest priority.^{16, 21}

To promote appropriate orientation as the programs of the medical schools move further into communities, it is recommended to the Chairman of the Board of Governors of UNC that a practicing physician, named by the North Carolina Medical Society, be added as an ex officio member of the proposed health subcommittee of the Committee on Educational Planning, Policies and Programs of that Board.¹³

Increased funding should be provided for primary care physician training in North Carolina. This might include grants to departments for graduates after four years of practice in North Carolina as primary care physicians.²²

The general requirements for all residency programs, as enforced through the AMA Medical Specialty Review Teams, should be broadened and supervised to assure increased emphasis on the exposure of house officers to meaningful experiences in health and medical service outside the university medical center; orientation to the social and economic aspects of medical practice should be included.²³

It is important, in keeping with a recently adopted AMA goal, that at least 50 percent of all medical graduates enter residency training in the primary care specialties in the coming years.²⁴

Health care delivery systems

The Office of Comprehensive Health Planning in the North Carolina Department of Administration has the responsibility of planning to meet the health needs of the people in North Carolina. Inadequate primary care services have been identified as a major health problem; yet, there are no primary care practicing physicians on the Comprehensive Health Planning Advisory Committee. There should be at least five practicing physicians on this Committee.²⁵

County medical societies, as far as possible, should consider taking on a "population frame of reference" in which physicians accept not only an individual responsibility to individual patients but also cooperate by establishing responsibility to the geographic areas.²⁶ The regional approach for underserved areas, using satellite clinics which are staffed by health care teams composed of an allied health professional under physician supervision, is being implemented in North Carolina.¹⁷

Additional studies should be undertaken to deter-

mine newer methods of transportation to bring the needy to areas of existing health services.¹⁶

Efforts underway by the Emergency Medical Service Program to centralize the provision of emergency medical services in the community and to eliminate duplicate staffing of emergency rooms in hospitals which are close together are important. Efforts should be continued to find more efficient and less costly ways to provide non-emergency, unscheduled care than by use of hospital emergency rooms.¹⁵

Community responsibility

There is an urgent need today for citizens in communities to examine their medical services' strengths and deficiencies. The people must establish the means for planning to assure optimum quality and continuity of comprehensive health services, working through the designated regions of the Office of Comprehensive Health Planning in cooperation with county medical associations. Every effort should be made on a regional and geographic basis to develop not only this entry point and access to primary care, but also the necessary secondary care in rural areas and backup tertiary care in strategically located medical centers. It is important for each community health planning committee with leadership from community physicians to establish long-term goals to be accomplished in a stepwise fashion.²⁷ These goals should be as follows:

To make quality health care available for all people in the region: (1) Start with improvements in the area's transportation system to bring people to available physicians and hospitals in the region; (2) Secure cooperation of community colleges to train medical and dental assistants; (3) Contract with health departments to provide public health nurses; (4) Develop plans for providing new medical dental clinics to help in recruitment of health personnel; (5) Seek to enlist the cooperation of medical and dental societies to provide added services; (6) Contract with local hospitals to establish emergency services; and (7) Establish improved ambulance services with better training and equipment for ambulance attendants.²⁷

To improve the family's ability to handle health problems: (1) Health education courses in schools for adults and children should be improved; (2) First aid courses for each family should be emphasized; (3) Self-help courses should be taught; and (4) Rural safety and accident prevention programs should be made available.²⁷

References

1. Forsyth County Medical Society Resolution to the 1973 NC Medical Society House of Delegates . . . referred to the Executive Council for consideration.
2. *Rural Health Care Needs*, address by Len Hughes Andrus, MD, Professor and Chairman of Department of Family Practice, School of Medicine, University of Calif., 12-10-73.
3. *Distribution of Physicians in the United States, 1971*, AMA, Chicago, 1972. ("Rural" refers to AMA county classifications 1-4; "urban" refers to classification 5-9. The US figures refer to the US, excluding North Carolina.)
4. Population figures from 1970 Census of Population, Advance Report PC (VI)-35, US Department of Commerce, 1970. (Total physicians, non-federal, from Roster of Registered Physicians in the State of North Carolina.) Board of Medical Examiners of the State of North Carolina, March 1, 1972. (Six most populous counties were Cumberland, Forsyth, Gaston, Guilford, Mecklenburg, and Wake. Six least populous were Tyrrell, Clay, Camden, Hyde, Graham, and Currituck.)
5. Report of the Committee to Study the Request of East Carolina University for a Second Year of Medical Education, Report to the UNC Board of Governors, December 29, 1972, p. 67. Supplemented by telephone communications with medical schools for graduates 1958-1960.
6. *Medical School Alumni, 1967*, AMA, Chicago, 1968, pp. 528-530.
7. Derived from computer analysis of 1972 AMA Master File computer tape for North Carolina by Division of Education and Re-

- search in Community Medical Care, UNC School of Medicine.
8. *Health Resources Statistics, Health Manpower and Health Facilities, 1972-1973*. US Department of Health, Education, and Welfare, 1973, pp 192, 196, 197.
 9. Telephone survey of Sept 1, 1972, residency positions filled by Division of Education and Research in Community Medical Care, University of North Carolina at Chapel Hill, 1973.
 10. *A Statewide Plan for Medical Education in North Carolina*—Report of the Panel of Medical Consultants to the Board of Governors of the University of North Carolina (9/21/73).
 11. *Expanding the Supply of Health Services in the 1970s*. Report of the National Congress on Health Manpower, sponsored by The Council on Health Manpower of the AMA (10/22-24/70).
 12. Actions of NC Medical Society House of Delegates, May 1973.
 13. Recommended Actions Consistent with the Report of the Panel of Medical Consultants on a Statewide plan for Medical Education in North Carolina, UNC Board of Governors.
 14. Senate Bill 301, General Assembly of North Carolina, 1973 Session.
 15. Statement by State Emergency Medical Services Advisory Council, NC Department of Human Resources (9/20/73).
 16. Outline of Proceedings—Conference on Access to Health Care. By NC Medical Society and NC Regional Medical Program (9/9-10/73).
 17. NC Medical Society Executive Council (10/73).
 18. Priorities for Increasing Availability of Health Services in Rural Areas—AMA House of Delegates, 6/72.
 19. Written communication to LH Fountain from RM Ball, Commissioner for Social Security, US Department of HEW, 3/22/73. (Resource information only.)
 20. Written communication from Dr. Allesen M Alderman, President, NC Academy of Family Practice (12/10/73).
 21. Medical school expands off campus. *American Medical News*, 10/1/73. ("For each of the past four years, more than 50 percent of the senior medical students time was spent in rotations off the Indianapolis campus"—University of Indiana).
 22. Senate Bill 858, General Assembly of NC, 1973 Session.
 23. AMA Council on Medical Education. *Essentials of Approved Residencies*, p 351.
 24. AMA House of Delegates, June, 1973.
 25. Membership Comprehensive Health Planning Advisory Committee, NC Department of Administration.
 26. Fenderson DA: Special Communications—Health manpower development and rural services. *JAMA* 225: 1627-1631, 1973.
 27. Guidelines: *Community Organization for Health Services in Rural Areas*, AMA Council on Rural Health (4/16/71).

REPORT N

Subject: Purchase of Property Adjacent to the Medical Society Parking Area on Bloodworth Street in Raleigh
 Referred to: Reference Committee No. I

The May 5, 1974, meeting of the Executive Council voted approval of the purchase of property adjacent to the Medical Society parking area fronting on Bloodworth Street in Raleigh. The action was based on the recommendation of the Chairman of the Committee on Personnel and Headquarters Operation and the Chairman of the Committee on Finance.

Price of the house and lot, encompassing 5,943 square feet and identified as the property of Mrs. N. G. Fontelle of Raleigh, is \$16,000.

REPORT O

Subject: Amendment to the Medical Practice Act
 Referred to: Reference Committee No. I

The May 5, 1974, meeting of the Executive Council approved a recommendation of an ad hoc Liaison Committee between the Board of Medical Examiners and the Medical Society that the House of Delegates be requested to endorse an amendment to the North Carolina Medical Practice Act.

The Executive Council made minor word changes in the recommendation of the ad hoc Committee so that the recommendation now reads as follows:

The Executive Council requests the House of Delegates to endorse an amendment to the Medical Practice Act to the effect that the Board of Medical Examiners may revoke or restrict a license to practice medicine for lack of professional competence and that such amendment be incorporated in Section 90-14 of the Medical Practice Act.

It was also the recommendation of the Council that the ad hoc Committee be continued by the incoming

President so that they might continue to meet for the purpose of making further recommendations to implement the recommendation if necessary.

SUMMARIES OF EXECUTIVE COUNCIL MINUTES

You have also received in your packet a summary of the three sessions of the Executive Council throughout the year. Dr. Gilbert and members of the Council stand ready to answer questions if you have them.

Are there questions concerning the other actions of the Executive Council?

Lest you be confused, the reports are lifted from the summaries. The summaries do contain some actions of the Executive Council but not necessary to be approved by the House of Delegates.

DR. WILLIAM ROMM: I move that these summaries be accepted.

DR. PASCHAL: Second.

SPEAKER DAVIS: Discussion of the motion?

[No response]

If not, those favoring the motion please say "aye"; opposed "No."

The summaries of the sessions of the Executive Council are accepted.

RESOLUTIONS

We move now to the resolutions and again you have copies of them, of course, in your packets on yellow sheets.

Now, you will notice and I think you have it in your packets but not listed on your agenda, a Resolution 4-A has been submitted and Resolution No. 14 came from the Executive Council, but has been circularized. It is not listed on your agenda.

Resolution: 1

Introduced by: Edgecombe-Nash County Medical Society

Subject: Professional Standards Review Organizations (PSRO)

Referred to: Reference Committee No. II

WHEREAS, Part B, Title XI of the Social Security Act as amended by P.L. 92-603 (known as PSRO) will allow government snooping into the files of private patients as well as into the files of those receiving assistance through Social Security, such as Medicare and Medicaid, causing the harassment of physicians, and

WHEREAS, it will result in standardization and mediocrity in the practice of medicine by setting up national norms of diagnosis and treatment implemented through the use of computers, and

WHEREAS, enforcement of PSRO would destroy the freedom of physicians to exercise independent judgment in caring for Medicare and Medicaid patients by forcing them to conform to government-imposed "norms" of diagnosis and treatment, and

WHEREAS, standardization of medical care will seriously impair the quality of medical care to the detriment of these patients by restricting a physician's liberty to use his own judgment, skill and knowledge, freely and without interference from government bureaucrats, and

WHEREAS, physicians who deviate from government's arbitrary "norms" will be subject to punishment,

no matter how much harm to the patient might result from adherence to the norms, and

WHEREAS, this unjust law could be employed to subject physicians to public scorn and ridicule and thereby undermine public confidence in the medical profession, and

WHEREAS, justification for the PSRO law is based on the false assumption that government can effectively improve medical quality and costs and the misrepresentation that physicians are responsible for rising health care costs whereas the blame actually lies with recklessly extravagant government, and

WHEREAS, Congressman John R. Rarick (D-La.) has introduced H.R. 9375 calling for repeal of the PSRO provisions of P.L. 92-603.

THEREFORE, BE IT RESOLVED that the members of the Edgecombe-Nash Medical Society in regular session this 14th day of November 1973 request and petition their fellow physicians, the North Carolina Congressional delegation, every member of both Houses of the United States Congress and both Houses of the North Carolina Legislature to work for the passage of the aforementioned Rarick bill calling for repeal of PSRO, and that copies of this resolution be forwarded to the aforementioned individuals, to all District Councilors and component county societies of the North Carolina Medical Society and submitted to the North Carolina Medical Society as a Resolution for action at the Annual Meeting in May 1974.

Resolution: 2

Introduced by: Scotland County Medical Society

Subject: Repeal of PSRO Act

Referred to: Reference Committee No. II

RESOLVED, that the Scotland County Medical Society supports the efforts of 30 U.S. Representatives in obtaining the repeal of the PSRO Act.

RESOLVED, that the Scotland County Medical Society urges the North Carolina Medical Society to introduce such a resolution at the AMA House of Delegates.

Resolution: 3

Introduced by: Pitt County Medical Society

Subject: Professional Standards Review Organization

Referred to: Reference Committee No. II

WHEREAS, PSRO empowers government agents to inspect clinical records, thereby destroying the patient's right to privacy, and

WHEREAS, the PSRO empowers government to take control of clinical and administrative aspects of patient care from doctor and patient, conferring it upon government, and

WHEREAS, rising costs, brought about by a deliberate government policy of a managed economy and inflation (increasing minimum wage, deficit spending) doom cost control to failure, and

WHEREAS, the inevitable failure of PSRO to control medical care costs will be blamed on the practicing physician and on medical societies,

THEREFORE, BE IT RESOLVED that the Pitt County Medical Society:

1. Opposes PSRO,
2. Instructs its delegates to the annual meeting of the N. C. Medical Society to initiate and support resolutions and actions in opposition to PSRO.

And, THEREFORE, BE IT FURTHER RESOLVED:

1. That the House of Delegates, acting for the members of the State Society, make its resolution in opposition to PSRO and initiate appropriate measures in support of this position.
2. That the N. C. State Medical Society not lend its support to the appropriation by the government in the name of PSRO of functions belonging to physicians, patients, medical societies, Boards of Medical Examiners, and local administrative agencies.

Resolution: 4

Introduced by: Pitt County Medical Society

Subject: Requirement of Joint Commission on Accreditation of Hospitals for Detailed Delineation of Hospital Staff Privileges

Referred to: Reference Committee No. II

WHEREAS, the Joint Commission on Accreditation of Hospitals has directed that hospital staffs describe in minute detail each surgical procedure and each medical treatment that each of its staff members is qualified to perform, and

WHEREAS, this cataloging of allowable treatment will tend to be restrictive and intimidating to the conscientious practitioner as his skills, technique and mode of treatment are constantly changing. Further the need for this self-imposed regulation has not been shown and under the present system there has been a constant and steady improvement in the skill of hospital staff members, and

WHEREAS, the ultimate aim of this ruling is to furnish a technique of our own making that will make it easy for third parties, lawyers and hospital administrators to coerce or restrict a physician's activities; therefore be it

RESOLVED, that the Pitt County Medical Society go on record opposing the detailed delineation of hospital staff privileges; and be it further

RESOLVED, that the North Carolina Medical Society go on record opposing this ruling.

Resolution: 4-A

Introduced by: Beaufort-Hyde-Martin-Tyrrell-Washington County Medical Society

Subject: Delineation of Hospital Privileges by Specific Procedure

Referred to: Reference Committee No. II

WHEREAS, within the framework of the concept of the PSRO Law, Hospital bylaws would be requested to delineate privileges within a specialty by specific procedures; and

WHEREAS, such a policy would be unjustly binding to community hospitals with limited staff and make them unjustly open to litigation;

THEREFORE, BE IT RESOLVED that the Beaufort-Hyde, Martin, Tyrrell, Washington County Medical Society go on record as considering such action impractical and unjust;

And, THEREFORE, BE IT FURTHER RESOLVED: that the North Carolina Medical Society act against implementation of such requirements.

Resolution: 5

Introduced by: Moore County Medical Society
 Subject: Increased Activity in the Area of Public Relations and Legislative Contact
 Referred to: Reference Committee No. I

WHEREAS, the private practice of medicine is at one of its most crucial crossroads today, and

WHEREAS, inflation is rapidly eroding into the dollars that the State Medical Society has to spend, and

WHEREAS, we have just paid out final assessment for an appropriate Medical Society headquarters building, and

WHEREAS, we need added monies for public relations and legislative contact,

BE IT RESOLVED that the North Carolina Medical Society increase its activity in the area of public relations and legislative contact; and, further, that the North Carolina Medical Society dues be raised as necessary to support this increased activity.

Resolution: 6

Introduced by: Nash-Edgecombe County Medical Society

Subject: Resolution on Creating Improved Communications Between Hospital Staffs through County and State Medical Societies

Referred to: Reference Committee No. I

WHEREAS, the rapid pace of change in the practice of medicine and the continuing attempts at imposing controls on physicians make it imperative that all physicians be informed about changes or contemplated changes in order to implement them or take action against them, and

WHEREAS, an individual hospital staff might be singled out as a test case for proposed changes without other hospital staffs having knowledge of the action which might later affect them, and

WHEREAS, a broader base of experience can be drawn upon in arriving at solutions if all are informed, therefore,

BE IT RESOLVED that the North Carolina Medical Society inform every member of the Society through the President's monthly message or a letter from the Executive Secretary whenever there are attempts by a hospital administrator, the Joint Commission on Accreditation of Hospitals, or a federal agency to impose new regulations or controls over a hospital staff if the request is made through a county medical society.

Resolution: 7

Introduced by: Nash-Edgecombe County Medical Society

Subject: Dissolution of the North Carolina Medical Peer Review Foundation, Inc.

Referred to: Reference Committee No. II

WHEREAS, Congress passed Public Law 92-603 in October of 1972, Section 249(f) of which calls for the establishment of a network of Professional Standards Review Organizations, and

WHEREAS, the Executive Council of the North Carolina Medical Society has approved Articles of Incorporation for a Statewide Foundation for Peer Review and

WHEREAS, we believe private physicians and surgeons should re-declare their continued dedication to;

1. The high ethics of our profession, and
2. The free and complete exercise of our independent medical judgment solely in the service of our individual patients.

THEREFORE, BE IT RESOLVED that:

1. We will not collaborate with any scheme that impairs in any manner the conscientious, confidential, loyal, and mutual responsibility between patients and their personal physicians, and
2. Accordingly, we will not collaborate with Professional Standards Review Organizations, since this scheme inherently conflicts with the best interests of patients, and
3. That all component societies of the North Carolina Medical Society join in our refusal to collaborate with political medicine, and
4. That the North Carolina Medical Society by action of the House of Delegates withdraw its support and dissolve the North Carolina Medical Peer Review Foundation, Inc.

Resolution: 8

Introduced by: Nash-Edgecombe County Medical Society

Subject: Resolution on Delineation of Privileges

Referred to: Reference Committee No. II

WHEREAS, the State Board of Medical Examiners is the legal examining and licensing body for physicians in the State of North Carolina, and

WHEREAS, attempts by the Joint Commission on the Accreditation of Hospitals and hospital administrators to require delineation of privileges for physicians beyond the customary departmental requirements as a requisite for staff privileges is an infringement upon the authority of the State Board of Medical Examiners, and

WHEREAS, the specific delineation of privileges could create new avenues for medico-legal problems for physicians in this time of increasing medico-legal awareness, and

WHEREAS, the highest standard of medical care the world has ever known has been attained by cooperation between the medical profession and the Joint Commission on the Accreditation of Hospitals, but specifically not by regulation of the medical profession by the Joint Commission on the Accreditation of Hospitals, therefore

BE IT RESOLVED that the members of the Edgecombe-Nash County Medical Society will not be regulated by and controlled by the Joint Commission on the Accreditation of Hospitals to the extent of submitting to a requirement for the delineation of privileges beyond that which has been customary in a departmentalized hospital in order to secure hospital staff privileges.

Resolution: 9

Introduced by: Cleveland County Medical Society

Subject: Professional Standards Review Organization

Referred to: Reference Committee No. II

RESOLVED that the North Carolina Medical Society should instruct its delegates to the AMA to introduce a resolution instructing the AMA to actively work for the repeal of the present PSRO amendment to the Social Security Act.

Resolution: 10

Introduced by: Cleveland County Medical Society
 Subject: Chiropractors on the Board of the North Carolina Division of Health Services
 Referred to: Reference Committee No. II

RESOLVED that the North Carolina Medical Society request Governor Holshouser to remove chiropractors from the North Carolina Division of Health Services.

Resolution: 11

Introduced by: Anson County Medical Society
 Subject: Opposition to Chiropractic School Accreditation and Repeal of Legislation Recognizing Chiropractors as being Eligible for Medicare and Medicaid Funds
 Referred to: Reference Committee No. II

WE, the Anson County Medical Society of Anson County, North Carolina, go on record as not lending support to any legislation which would give recognition to any chiropractic school regarding accreditation. We further believe recognition of chiropractors as being eligible for Medicare and Medicaid funds for treatment or X-rays of patients is unjustified and the State Medical Society should work toward repeal of this legislation by any manner possible.

Resolution: 12

Introduced by: Anson County Medical Society
 Subject: Ending Cost of Living Council Controls and Expiration of the Present Economic Stabilization Act
 Referred to: Reference Committee No. II

WHEREAS, Phase III of the economic control program has been directed only to a limited segment of the economy and others have been permitted to be de-controlled causing an unfair hardship on the medical profession, WE, the Anson County Medical Society support and encourage efforts to have those controls rescinded immediately. We further support measures to end all controls on all areas of the economy with the expiration of the present Economic Stabilization Act, April 30, 1974.

We believe that since enactment in November of 1971 there has been no evidence that such controls have been fair or have slowed inflation of our economy in general.

If these controls are in fact allowed to be extended to physicians after April 30, 1974, we contest this to be discrimination and against the U.S. Constitution as our rights as individual citizens.

Resolution: 13

Introduced by: Mecklenburg County Medical Society
 Subject: Membership of the Council on Medical Education of the AMA
 Referred to: Reference Committee No. II

WHEREAS, the Bylaws of the AMA provide that the Council on Medical Education shall consist of ten active members, at least one of whom shall be from practice and have no academic connections, and

WHEREAS, this has been taken literally over a period of many years with the result that the Council has become dominated by academicians to the point that it is virtually a A.A.M.C. appendage, and

WHEREAS, the community hospital graduate educa-

tion programs, where a substantial number of trained are and a substantial number of physicians are, have all but been excluded from having a voice in medical education during these critical times, and

WHEREAS, the Council on Medical Education is deeply involved not only in graduate medical education allied health personnel, and either directly or indirectly with certification, re-certification, licensure and many other areas which affect the practicing physician in his daily activities; therefore be it

RESOLVED that the Mecklenburg County Medical Society feels that there should be more balance in the Council of Medical Education of the AMA between men in practice and A.A.M.C. members; therefore be further

RESOLVED that the Mecklenburg County Medical Society proposes that the Council on Medical Education shall consist of ten active members of which not less than one nor more than five shall be members of medical school faculty.

Resolution: 14

Presented by: President George G. Gilbert, for the Executive Council

Subject: Encouraging Membership in N. C. MEDPAC
 Referred to: Reference Committee No. I

WHEREAS, Government encroachment into the private practice of medicine increases daily at all levels of government; and

WHEREAS, there is an ever increasing need to elect candidates to political office whose beliefs reflect those of physicians and represent the free enterprise system of health care delivery; and

WHEREAS, more and more physicians are seeking PAC dollars for candidates at all levels; and

WHEREAS, MEDPAC can only meet these demands through increased memberships and dues monies;

THEREFORE, BE IT RESOLVED that the House of Delegates of the North Carolina Medical Society go on record as favoring the following:

1. Every member of this House become a dues paying member of MEDPAC
2. Strongly recommend that every member of the North Carolina Medical Society and Auxiliary members become dues paying members of MEDPAC
3. Urge the Executive Council and all State and County leadership of the North Carolina Medical Society to become sustaining members of MEDPAC;

And, THEREFORE, BE IT FURTHER RESOLVED: that the North Carolina Medical Society delegates to the American Medical Association House of Delegates introduce a similar resolution at the next Annual Meeting of the American Medical Association House of Delegates and actively work for its passage in support of AMPAC so as to enhance medicine's political activities on the national level.

There is one change in Reference Committee assignment. This relates to Resolution No. 8 and we would like to change that and refer it to Reference Committee II simply because its composition is consistent with other items to be discussed by that Reference Committee.

Would the committee chairman please take note of that.

Resolution No. 8 to Reference Committee II rather than to Reference Committee I.

Again, questions concerning these resolutions are in order, but no debate. If not, may I have a motion that these resolutions be accepted as the property of the House of Delegates and be referred to the Reference Committees as indicated?

[The motion was made and seconded from the floor.]

If there is no discussion, all those in favor say "aye"; opposed "no."

These resolutions are accepted and are referred.

NOMINATING COMMITTEE

At this time, we will again have about a ten minute recess for the purpose of the Third, the Fifth, the Seventh and the Ninth Districts caucusing to nominate a member from their District as their representative on the Nominating Committee.

Why only these four Districts? Simply because we are now in our second year of staggered terms on the Nominating Committee, being that the terms of office of the representatives of these Districts have expired, new members should be nominated only from these Districts.

As you realize we are getting to a three year term on the Nominating Committee and the man nominated and elected subsequently by the House today to the Nominating Committee will serve a three year term.

The question comes up, those who are going off of the committee who have not served a full three year term as to their eligibility for re-election—they are eligible.

One must serve a full three year term to lose his eligibility so current members or any member who has not served a full three year term is eligible for nomination to the committee. Are there questions concerning this procedure?

DR. PHILIP NAUMOFF [Mecklenburg County]: Mr. Chairman, in order to be a member of the Nominating Committee you must be a delegate to this House, is that correct?

SPEAKER DAVIS: That is correct.

DR. NAUMOFF: Suppose a man is elected today for a three year term and then after a year or two is not elected back as a delegate to the House, what happens to his nomination?

SPEAKER DAVIS: I would think that all of us realize if this matter is contested the Executive Council has to make the ultimate judgment on it. However, in going over the bylaws I think it is more likely one would interpret that a member of the Nominating Committee must be a delegate at the time of election and so I think we should follow that policy unless a matter does become contested. It would then go to the Executive Council.

Is there any contrary opinion? Any discussion?

[No response]

So, a ten minute recess and could I ask the Third, Fifth, Seventh and Ninth Districts to forward their name of their nominee immediately to the podium. They must then be elected by the House. We stand in recess.

[Whereupon there followed a twenty minute recess for the purpose of District Caucuses.]

SPEAKER DAVIS: Will the House please be in order? We now have nominated for a position on the Nominating Committee:

From the Third District, Dr. Thomas Craven of Wilmington.

From the Fifth District, Dr. Charles T. Johnson, Jr., of Red Springs.

From the Seventh District, Dr. James Greenwood of Charlotte.

And, from the Ninth District, Dr. James H. Segars of Lenoir.

May I have a motion that these men be elected to the Nominating Committee.

[The motion was made and seconded from the floor.]

Those in favor of the motion please say "aye"; opposed "no."

These men are elected for a three year term to the Nominating Committee and I would ask that they and the continuing members of the Nominating Committee meet on the podium immediately following adjournment of this meeting to meet with the Secretary for organization of the Nominating Committee.

Is there New Business to come before the House?

DR. JOHN L. McCAIN: Mr. Speaker!

SPEAKER DAVIS: Would you state the reason for your rising?

DR. McCAIN: I would like to present a late resolution.

SPEAKER DAVIS: Would you briefly outline the resolves of this?

DR. McCAIN: There are three brief whereases that will make the resolve a little more understanding if I could have permission to read this briefly.

SPEAKER DAVIS: All right, sir, just a minute for an explanation of procedure.

As you know, late resolutions must be accepted by two-thirds vote of the House; before we get into any discussion of the resolution we need to know the nature of it and if you will please read the resolves.

Just the resolves if you will.

DR. McCAIN: Therefore, be it.

RESOLVED, that it be urged that medical specialty examining boards articles of incorporation and bylaws restrictions for membership that are contrary to the "peer" concept be removed, and be it further,

RESOLVED, that this resolution be referred to the AMA House of Delegates.

SPEAKER DAVIS: You have heard the substance of Dr. McCain's proposed resolution. He moved that the House accept this late resolution and have it referred to a Reference Committee.

Is there a second to his motion?

[The motion was seconded from the floor.]

Is there any discussion on acceptance of this late resolution? [No response]

If not, those favoring acceptance please say "aye"; opposed "no." It's the feeling of the Chair that two-thirds are in favor.

Would those favoring the motion please raise your hand. [Whereupon there followed a showing of hands.]

Those opposed please raise your hands. [Whereupon there followed a showing of hands.]

It is still the strong impression from the podium

that the motion is carried. The resolution is accepted and it will become Resolution No. 15 and will be referred to Reference Committee II.

Resolution: 15

Presented by: Wilson County Medical Society

Subject: Medical Specialty Examining Boards

Referred to: Reference Committee No. II

WHEREAS, plans for recertification are being undertaken by many of the medical specialty examining boards, and

WHEREAS, this House of Delegates has approved the desirability of the membership of these boards being peers of those they seek to examine, and

WHEREAS, in some instances, the legal instruments setting up these boards are contrary to this concept, despite this expressed desirability,

THEREFORE, BE IT RESOLVED that it be urged that medical specialty examining boards' articles of in-

corporation and bylaws restrictions for membership that are contrary to the "peer" concept be removed, and

BE IT FURTHER RESOLVED that this resolution be referred to the AMA House of Delegates.

SPEAKER DAVIS: It is accepted and it is referred.

One other word of explanation, I've been told that the Commission for Medical Facility Services and Licensure has gone back to its former term of Medical Care Commission and it is that commission that we have today elected Dr. Hugh McManus to.

Is there other business to come before the House?
[No response]

Prior to adjournment, let me with all sincerity thank you for your cooperation today. I ask that all of you possible attend the Reference Committee sessions tomorrow at two o'clock and we will reconvene back here on Tuesday at two o'clock. We stand adjourned until two o'clock on Tuesday.

[The meeting adjourned at four-twenty o'clock.]

Abridge Minutes of the Meetings of the House of Delegates

TUESDAY AFTERNOON SESSION

May 21, 1974

The Second Meeting of the House of Delegates at the 120th Annual Meeting of the North Carolina Medical Society convened at two-fifteen o'clock, Dr. James E. Davis, Speaker of the House of Delegates, presiding.

SPEAKER DAVIS: Will the House please be in order? First of all, I would like to recognize our President who has a message for the House.

PRESIDENT GILBERT: This represents a little good news for a change. This is a telegram that was sent yesterday from Dr. Russell Roth, President of the AMA to me in behalf of the State Society and I will read it:

DEAR DR. GILBERT:

IT IS ALWAYS A PLEASURE TO BE THE OFFICIAL BEARER OF GOOD TIDINGS. IT IS MY CHEERFUL PRIVILEGE TO INFORM YOU THAT THE NORTH CAROLINA MEDICAL SOCIETY HAS ACHIEVED THE DISTINCTION OF BECOMING THE THIRD STATE MEDICAL SOCIETY TO STRENGTHEN THE AMA MEMBERSHIP THIS YEAR. THIS MARKS THE FIFTH CONSECUTIVE YEAR THAT NORTH CAROLINA HAS EXCEEDED THE AMA DUES PAYING MEMBERSHIP THAT IS RECORDED FOR THE PRECEDING YEAR. THIS INDICATES THE IMPORTANCE THAT NORTH CAROLINA PHYSICIANS PLACE UPON THE AMA.

CONGRATULATIONS TO YOU, THE OTHER NORTH CAROLINA MEDICAL SOCIETY OFFICERS AND TRUSTEES AND TO YOUR FINE STAFF FOR EXHIBITING THE LEADERSHIP THAT HAS PERPETUATED A UNIFIED PROFESSION IN THIS TARHEEL STATE.

CORDIALLY YOURS, RUSSELL B. ROTH.

I thought you ought to hear this! [Applause]

SPEAKER DAVIS: Thank you, Dr. Gilbert.

May we please have a report from the Credentials Committee, Dr. John Payne.

DR. JOHN PAYNE: Mr. Speaker, we have 133 qualified delegates.

SPEAKER DAVIS: 133! Thank you, sir.

So a quorum is in the House and the House is ready to do business.

I would first of all like to appoint tellers in case they are needed this afternoon and I will ask Dr. Roy Bigham to serve as chief teller and with him Dr. Philip Pearce, Dr. Shahane Taylor, Dr. Ben Warren and Dr. Walter Burwell.

As we proceed with the reports of the Reference Committees, a simple reminder if I may, please keep in mind that the primary issue under discussion and under vote as we go along is the basic resolution.

The Reference Committee may amend or offer a substitute resolution to this, but when they make a recommendation it is only that and so when we are voting you desire to vote or when you're voting keep the primary issue in mind.

We will proceed with the report of Reference Committee I and I'll ask the members of this committee

to please come forward and ask Dr. John McCain to assume the podium.

REFERENCE COMMITTEE I

DR. MCCAIN [Chairman, Reference Committee I]: I'd like to introduce the two other members of the committee, Dr. Thomas Dameron and Dr. E. T. Marshall.

The committee report and recommendations are as follows:

REPORT A

Report "A," Subject: The Annual Budget Estimates for 1974 from the Executive Council.

The Reference Committee recommends approval of Report "A."

SPEAKER DAVIS: All of you have a copy of Report "A" before you. The Reference Committee, of course, has three members on it so when they move or recommend, it comes with a second.

This has to do with the annual budget, so it has been moved and seconded that this report on annual budget be adopted.

Are there any questions concerning the budget? Any discussion on the motion?

If not, those favoring adoption of Report "A" please say "aye"; opposed "no."

It is adopted.

REPORT B

DR. MCCAIN: Report "B," subject: Report of the ad hoc Committee to Study and Recommend a Salary or Increase in Allowance for the President from the Executive Council.

The Reference Committee recommends approval of Report "B."

SPEAKER DAVIS: Report "B" is before you with a recommendation for its adoption.

Are there questions or is there discussion?

All those in favor of adopting Report "B" please say "aye"; opposed "no." It is adopted.

REPORT C

DR. MCCAIN: Report "C." Subject: Request that the Section on Ophthalmology and Otolaryngology be divided into a Section on Ophthalmology and a Section on Otolaryngology, from the Executive Council.

The Reference Committee recommends approval of Report "C."

SPEAKER DAVIS: Report "C" which simply separates these two sections and makes individual sections is before you with a recommendation for adoption.

Is there discussion? [No response]

If not, those favoring adoption please say "aye"; those opposed "no." It is adopted.

REPORT P

DR. MCCAIN: For continuity of concern we would like to have Report "P" considered next.

Report "P," Subject: Proposed changes in the Con-

stitution and Bylaws from the Executive Council.

It's divided into three parts.

Part 1 has to do with Chapter IV, Section 2, page 16, regarding student membership and provides for election of their own delegates.

The Reference Committee recommends approval of this portion of Report "P."

SPEAKER DAVIS: As you notice, Report "P" is in three sections. The Reference Committee has a recommendation concerning each part. The Chair thinks it better to consider this one part at a time unless there is disagreement.

Part one concerning election and certification of student members is before you with a recommendation for adoption.

Is there discussion? [No response]

If not, those favoring adoption, please say "aye"; opposed "no." Part one is adopted.

DR. McCAIN: Part two: Chapter XI, Section 1, page 54, addition of Sections on Neurological Surgery, Otolaryngology and Ophthalmology as editorially corrected during the first session of the House of Delegates.

The committee recommends approval of part two of Report "P."

SPEAKER DAVIS: Part two and I hope all of you have a copy of this, is before you. It is recommended to be adopted.

Are there questions or discussion? [No response]

If not, those favoring adoption, please say "aye"; opposed "no." Part two is adopted.

DR. McCAIN: The committee concurs that with the addition of new Sections, alterations should occur in the composition of the Blue Shield Committee as indicated in Chapter X, Committees, Section 16 of the Committee on Blue Shield in the Constitution and Bylaws.

Part three: Article IV, Section 6, page 3—Intern-Resident Training Members.

This provides opportunity for membership in the North Carolina Medical Society for those in training outside of North Carolina.

The committee recommends approval of this change with the following editorial correction:

That on lines 134 and 136 and lines 156 and 158 "Joint Accreditation Committee on Hospitals" be changed to "Joint Commission on Accreditation of Hospitals."

The committee recommends approval of Report "P" as amended.

SPEAKER DAVIS: Part three of Report "P" is before you with a grammatical change and the Reference Committee recommends approval.

Is there discussion? [No response]

If not, those favoring approval say "aye"; opposed "no."

Part three is approved and if I may have a motion that the entire Report "P" as amended be adopted, I'd appreciate it.

[The motion was made and seconded from the floor.]

Those favoring adoption of the amended Report "P" please say "aye"; opposed "no." Report "P" is adopted, as amended.

REPORT J

DR. McCAIN: Report "J": Subject: Request for the establishment of a Section on Neurological Surgery from the Executive Council.

The committee recommends that Report "J" be filed.

The action item in this resolution has already been approved by this body.

SPEAKER DAVIS: Report "J" is before you.

The Reference Committee recommends that this be filed. Is there discussion? If not, those favoring filing of Report "J" please say "aye"; opposed "no." It is filed.

REPORT Q

DR. McCAIN: Report "Q." Subject: Constitution and Bylaws change regarding compulsory continuing education as a requirement for membership in the Society. It is from the Executive Council.

It was reported that many other state medical societies are in various stages of implementation of continuing education as requirement for membership.

The committee commends the action of the first session of the House of Delegates in its decision Sunday to have this incorporated as a change in the bylaws rather than a change in the Constitution, as this will allow subsequent changes to be accomplished by the House of Delegates more easily on a yearly basis to assure compliance to the will of the membership.

The committee recommends approval of Report "Q."

SPEAKER DAVIS: Report "Q" is before you.

The mechanism as outlined was adopted on Sunday to consider that as a bylaw change and its adoption as a bylaw change is recommended by the Reference Committee.

Those who might be following this will find it in Chapter 1, page 13, Section 5.

Is there any discussion of Report "Q"? [No response]

If not, those favoring adoption of Report "Q" the bylaw change please say "aye"; opposed "no." Report "Q" is adopted.

REPORT H

DR. McCAIN: Report "H." Subject: Compulsory Continuing Education as a Requirement of Membership from the Executive Council.

Considerable discussion was heard, both pro and con concerning the desired hours to be required, different categories of credit, methods of keeping records, enforcement of requirements, cost of staff time and provision for hardship allowances.

The committee recommends that Report "H" be amended by substitution of item No. 1 as follows:

That a minimum of 150 hours of continuing education per three years be required of each member of the State Medical Society, reportable on an annual basis.

It is felt that instead of making it 50 hours on an annual basis that by extending it to 150 hours in three years it gives more flexibility.

And, furthermore, the committee recommends that Report "H" be amended by substitution of item No. 4 by replacement of the second sentence of this item.

Item No. 4 would then read as follows:

That a form for certifying compliance with the above requirement be included with the annual notice of due

sent each physician. This form would then be returned along with the dues payment beginning with the 1976 dues.

The time of applicability of continuing education could not be had until January 1, 1975 and would be reportable at the time that statements are sent out in December, 1975 for the 1976 dues.

It is anticipated that a program of membership education would be undertaken to alert them that the time for initiation of measurement begins in January 1975 to be reported in December 1975.

And, furthermore, the committee recommends that Report "H" include the recommendation that the Committee on Medical Education be requested to study and recommend methods of awarding credits, processing and recording replies, managing cases of hardship and non-compliance and report their findings to the House of Delegates next year.

The committee recommends approval of Report "H" as amended.

SPEAKER DAVIS: Report "H" is before you. The committee has recommended three different changes. It would appear advantageous to consider these separately, unless I hear objection.

So we will go first to item one which changes the 50 hours per year to 150 hours per three years reportable on an annual basis.

Approval of this has been recommended. Is there discussion? Is it understood?

DR. BRUCE BLACKMON [Harnett County]: Dr. Blackmon from Harnett!

I'm concerned about what we're doing to our retired physicians in this. I don't believe it's clear to me just what happens to a fellow when he gets 62, 65 or 67 and retires.

Does he get to the point in three years where he can't write a prescription for the neighborhood youngster?

DR. McCAIN: This was brought out in the discussion. This would be categorized as a hardship case.

Another hardship case would be where a physician had a heart attack or a case where it might be considered one of his partners left and you had the whole load to carry by yourself.

The description of hardship cases should be studied and brought back so that consideration of these items could be included.

Another reason for starting when it does, beginning next January as beginning to count the time, this will allow consideration and study by the House of Delegates and would be available for consideration with the report from the Committee on Medical Education at the House of Delegates meeting next year to consider in more depth the items that you mentioned.

And, I would think the Committee on Medical Education would welcome your comments and suggestions if this is approved, that anyone would like to make.

DR. BLACKMON: Are we anticipating that this retired physician will lose his license to practice after three years if he has not kept up his training?

DR. McCAIN: This does not apply to his license. This applies to membership in the Medical Society.

SPEAKER DAVIS: Is there further discussion?

We're considering the substitute motion for item one of Report "H."

Those favoring adoption of the substitution please say "aye"; opposed "no." Item one is adopted.

We now move on to item four, again a substitute motion, that would remove item four and substitute for it the words that you see at the bottom of the page 3 of your Reference Committee report.

Is there discussion?

DR. MELVIN W. WEBB [Anson County]: Under number two, who will judge scientific literature reading?

DR. McCAIN: I hope this body right here will when the results—when it acts on the report of the Committee on Medical Education to the House of Delegates meeting next year.

SPEAKER DAVIS: We are considering item four and its substitution. Are there further questions or discussion?

If not, those favoring adoption please say "aye"; opposed "no." [There were a few dissenting votes.]

It appears that item four is adopted.

Then the paragraph at the top of page 4, your Reference Committee makes a recommendation that might be considered as item four of Report "H."

Acceptance of this and addition to Report "H" has been recommended by your Reference Committee.

Is there discussion? If not, those favoring adoption of item five please say "aye"; opposed "no." Item five is adopted.

The Reference Committee has recommended adoption of this entire Report "H" as amended. Discussion?

Those favoring please say "aye"; opposed "no."

Report "H" as amended is adopted.

REPORT O

DR. McCAIN: Report "O." Subject: Amendment to the Medical Practice Act.

This provides for revocation or restriction of a license for the lack of professional competence. It's from the Executive Council.

The committee recommends approval of Report "O."

SPEAKER DAVIS: Dr. McCain, this is of such importance, can you elaborate a little bit of what this entails and how it will be enforced?

DR. McCAIN: This gives the Board of Medical Examiners the authority to revoke or restrict a license of a physician for the lack of professional competence. If he's not measuring up to what should be done why this allows them to consider him in this light.

SPEAKER DAVIS: Heretofore, it has been on misconduct. Any questions on Report "O"?

DR. BLACKMON: I again, sir, would like to know if professional competence be tied in with his hours of study. We have a physician in the state who has had over 1200 deliveries since he was aged 70. I doubt seriously if this man is going back to school, yet I think he's doing a good job in what he's doing. Are we going to penalize this type of individual is what I'm concerned about?

DR. McCAIN: I would not think if he was providing good service that continuing education would be a component of this, as at the present time this is not included under the purview of the Medical Practice Act.

If he were providing inferior care or if there was a

lack of competence. I would think they would care to insert this as one of his criteria for continued licensure.

DR. RALPH V. KIDD [Mecklenburg County]: Ralph V. Kidd, Mecklenburg County!

I would like to know if we could define lack of professional competence in these others such as moral turpitude or criminal charges or criminal actions as stated against the physician during the act of professional competence and ability?

SPEAKER DAVIS: Dr. McCain!

DR. McCAIN: Can we defer to counsel.

MR. JOHN ANDERSON [Legal Counsel]: The present Medical Practice Act referred to as General Statute 90-18 describes and provides the grounds on which the Board of Medical Examiners may revoke or rescind a license.

This provision would clarify the power of the Board to mean that the Board could restrict or revoke a license for lack of professional competence, notwithstanding the doctor may in good faith or may have good morals or not be involved in any moral turpitude.

As to the matter of how do you determine his medical competence, the Board of Medical Examiners has a mechanism for doing this, for granting due process in doing it and it would be, of course, up to this group of physicians to make this determination, but once it's made this amendment in the Medical Practice Act would require legislative action and would make it easier to deal with this problem in our state.

SPEAKER DAVIS: Is there further discussion on Report "O"?

Adoption is recommended. Those favoring adoption, please say "aye"; opposed "no."

Report "O" is adopted.

REPORT N

DR. McCAIN: Report "N." Subject: Purchase of Property Adjacent to the Medical Society parking area on Bloodworth Street in Raleigh. It's from the Executive Council.

The committee felt that purchase of a rentable house in the middle of Raleigh for \$16,000 next to our Medical Society building was a good bargain.

The committee recommends approval of Report "N."

SPEAKER DAVIS: Report "N" is before you. The Executive Council has approved the purchase and Report "N" would approve the action of the Executive Council.

Is there any discussion? [No response]

Those favoring adoption of Report "N" please say "aye"; opposed "no." It is adopted.

REPORT R

DR. McCAIN: Report "R." Subject: proposed change in the Constitution and Bylaws regarding the Committee on Memorial Services.

This will allow services to be conducted by the Committee on Medicine and Religion. It's from the Executive Council.

The committee recommends approval of Report "R."

SPEAKER DAVIS: Report "R" actually eliminates the Committee on Memorial Services. Its adoption is recommended by the Reference Committee. Are there questions or is there discussion?

If not, those favoring adoption of Report "R" please say "aye"; opposed "no." It is adopted.

RESOLUTION NO. 5

DR. McCAIN: Resolution No. 5. Subject: Increased activity in the area of public relations and legislative contact. It's from the Moore County Medical Society.

The committee recommends approval by substitution of the following resolve:

Be it,

RESOLVED, that the North Carolina Medical Society increase its activity in the area of public relations legislative contact and governmental relations.

The second sentence recommending a dues increase was not felt necessary at this time as program enhancement was already being accomplished within the present budget.

The committee recommends approval of Resolution No. 5 as amended.

SPEAKER DAVIS: Resolution No. 5 is before you with a substitute motion which will eliminate the second part of the single resolve, that having to do with dues increase, but contains the substance of the first part of the resolve.

Is there any question about this?

If not, those favoring the adoption of Resolution No. 5 as amended please say "aye"; opposed "no."

The amended resolution is adopted.

RESOLUTION NO. 6

DR. McCAIN: Resolution No. 6, Subject: Resolution on creating improved communications between hospital staffs through county and state medical societies. It's from the Edgecombe-Nash County Medical Society.

The committee commends the Edgecombe-Nash County Medical Society for their concern in the need for improved communications between the hospital staff and county and state medical societies.

As the recommendations are already being carried out via the President's Newsletter, the committee recommends that Resolution No. 6 be filed.

SPEAKER DAVIS: Resolution No. 6 is before you with a recommendation that it be filed.

DR. LLOYD BAILEY [Edgecombe-Nash County]: I would like to move that we vote on this resolution.

We felt that this is necessary because there are instances where individual hospital staffs apparently are being singled out for action or treatment, one way or another, by various groups and it would be nice if all the members of the Society are informed at the same time when these things happen instead of hearing about an action six months later.

We felt that this resolution would set up a mandatory mechanism for improving communications across the state so that all of us could be informed in a timely manner about things that are important to all of us.

This doesn't change anything perhaps that's being done right now, but it does require the State Medical Society to distribute this information.

SPEAKER DAVIS: Resolution No. 6 we're considering the recommendation of the Reference Committee that this be filed.

Dr. Bailey could accomplish his desire if this motion

were defeated. We would then resort to the basic resolution. He states against filing.

(After further discussion and a voice vote which failed to indicate a clear decision, the speaker called for a standing vote.)

Now, will those favoring filing of Resolution No. 5 please stand.

Those against filing of Resolution No. 6 please stand.

DR. ROY S. BIGHAM, Jr.: (Chief Teller) Mr. Speaker, for filing 76, those against filing 61.

SPEAKER DAVIS: Resolution No. 6 then is filed.

RESOLUTION NO. 14

DR. McCAIN: Resolution No. 14, Subject: Encouraging membership in North Carolina MedPac. It's from the Executive Council.

Discussion was presented about the need for widespread support of the North Carolina MedPac. In the discussion of this resolution, it was pointed out that it included no inference of mandate or coercion.

The committee recommends approval of Resolution No. 14.

SPEAKER DAVIS: Resolution No. 14 is before you with the recommendation of the Reference Committee or its adoption.

DR. NAUMOFF: [Mecklenburg County] I am in favor of the resolution to encourage that every member of the North Carolina Medical Society become dues paying members of MedPac. But I object to two of the statements in the resolution on a basic principle.

First of all, number three which urges that the Executive Council and all state and county leadership of the North Carolina Medical Society become sustaining members of MedPac.

I am well aware of the fact that there is no coercion or mandate in this resolution. For those people who do not know what sustaining membership means, it means that instead of contributing \$20 per year, you are contributing \$100 per year.

I am opposed to anything that tells our county society leadership or presidents, or secretaries, or other person of leadership in the county as well as the state, as well as telling members of our Executive Council that we by urging them to become sustaining members in effect are telling them that we expect them to become sustaining members of MedPac. I think this would be voluntary.

I also object to number one which says that every member of this House become a dues paying member of MedPac on the same basis. Here again, I think delegates to this House should have the right to decide for themselves whether or not they want to become dues paying members of MedPac.

I therefore urge that we vote down the recommendation of Reference Committee I and that we approve a resolution amendment to read that, therefore, be it,

RESOLVED, that the House of Delegates of the North Carolina Medical Society go on record as favoring the following—just including number two which says, we strongly recommend that every member of the North Carolina Medical Society and Auxiliary become dues paying members of N. C. MedPac.

SPEAKER DAVIS: Dr. Naumoff speaks against ap-

proval of Resolution No. 14 and offers a substitute motion: Therefore, be it,

RESOLVED, that the House of Delegates of the North Carolina Medical Society go on record as favoring the following:

strongly recommend that every member of the North Carolina Medical Society and Auxiliary members become dues paying members of MedPac.

SPEAKER DAVIS: Is there a second to this substitute motion?

[The motion was severally seconded from the floor.]

The substitute motion that you have just heard is before you for discussion.

DR. J. ELLIOTT DIXON [Pitt County]: Dixon from Pitt! I would just like to ask Dr. Naumoff if he would consider striking Auxiliary members from that. We are speaking here of the Medical Society and we are asking our Auxiliary to do something that I think can be done very directly to the Auxiliary so I wonder if you would agree to striking the words "Auxiliary members"?

DR. NAUMOFF: Yes, I would and I even brought this up at the Reference Committee meeting that I didn't think we really had the right to tell the Auxiliary members what to do.

SPEAKER DAVIS: Substitute motion then has stricken from it "and Auxiliary members," from second line of number two.

Is there further discussion of the substitute motion?

DR. JOHN H. HALL [Guilford County]: Mr. Speaker, I oppose the substitute motion—I oppose the substitute motion and speak in favor of the original resolution. It is not telling, in my opinion, what the county officers have to do or what the Auxiliary members have to do, but rather is putting this House on record as favoring something which is long overdue.

As a matter of fact, the Auxiliary has already recommended the same for its members.

SPEAKER DAVIS: He speaks against the substitute motion.

Is there further discussion of this motion? If not, those favoring the substitute motion please say "aye"; opposed "no."

It appears that the "ayes" have it and the substitute motion carries.

REPORT G

DR. McCAIN: Please see the attached addendum regarding Report "G."

Report "G," Subject: Change in dates of annual meeting and survey of the membership regarding choice of May or September. It's from the Executive Council.

The committee felt that this report contained no action items.

The committee recommends that Report "G" be filed.

SPEAKER DAVIS: Report "G" is before you with the recommendation that it be filed.

Is there discussion? If not, those favoring filing of Report "G" please say "aye"; opposed "no." Report "G" is filed.

DR. McCAIN: I think that concludes my report. I would like to comment that the discussions during the hearings were very similar to that we've heard here today: views on both sides were presented and the committee attempted to steer a middle of the road course

about the comments and suggestions that were made.

I'd like to express my appreciation to Dr. Dameron and Dr. Marshburn for serving on this committee. Thank you.

SPEAKER DAVIS: I'd like to express the appreciation of the House to Drs. McCain, Dameron and Marshburn for a very fine job and we are most grateful to you.

May I please have a motion that the report of Reference Committee I as amended be adopted.

[The motion was severally made and seconded from the floor.]

Any discussion? Those favoring adoption of the amended Reference Committee report I please say "aye"; opposed "no." It is adopted. [Applause]

I now recognize President Gilbert for another introduction, please.

PRESIDENT GILBERT: Last fall, I had the honor of being invited to the annual convention of the Virginia State Medical Society and they treated me very royally, so I am proud to tell you that the President of the Virginia Medical Society, in turn, is now here as our guest and if you will just rise I want you to join me in welcoming Dr. James Martin, President of the Virginia Medical Society.

[Whereupon Dr. James Martin, President of the Virginia Medical Society stood up to be recognized and was accorded a standing ovation.]

REFERENCE COMMITTEE II

VICE SPEAKER CARR: Mr. President, Mr. Speaker, Members of the House of Delegates:

It is now my duty to turn to Reference Committee II and I'll ask Dr. Stewart and his committee members to please come forward to the podium.

Dr. Stewart, will you please stick to the ground rules that Dr. Davis set.

DR. ALBERT STEWART [Chairman, Reference Committee II]: Mr. Speaker, Reference Committee II met as scheduled on the 20th.

The meeting was well attended. The discussions were lively and informative. I want now to thank all those who came for their remarks. It was of tremendous help to us in making decisions about our recommendations.

I also would like to recognize and thank Dr. David S. Citron and Dr. Jack Hughes for their help on this committee.

The business before this committee consisted of five reports from the Executive Council and thirteen resolutions from various county societies.

We will begin with the reports.

REPORT D

Report "D": Guidelines for a medical director in a long-term care facility.

Your Executive Council has approved recommendations from the Committee on Chronic Illness that the North Carolina Medical Society endorse the principle that long-term care facilities should employ the services of a medical director, and that the Society endorse the guidelines for a medical director in a long-term care facility as adopted by the American Medical Association.

The Reference Committee understands that a long-

term care facility refers to an extended care facility and offers skilled nursing services on a continuing basis.

Realizing that in some areas the acute shortage of physicians would create problems of procurement for a facility, Reference Committee II amends this resolution by adding the words "where available," after the word "physician" in line 7 and recommends the approval of the amended report.

VICE SPEAKER CARR: Report "D" is before you for consideration to vote on Report "D" as amended. Is there discussion?

All in favor of Report "D" as amended please say "aye"; opposed "no."

The "ayes" have it and Report "D" as amended is accepted.

REPORT E

DR. STEWART: Report "E," Treatment of tuberculosis cases and potential cases.

The report is from the Executive Council which has approved the recommendation of the Committee on Chronic Illness, that renewed effort be made to identify and bring to treatment cases and potential cases, treatment be continued for at least two years for active or probably active disease, that the initial infectious phase be treated in a hospital, that the responsibility for outpatient treatment and epidemiologic investigation be shared with public health authorities and that the tuberculin skin test be recommended as the initial screening procedure of choice in tuberculosis case findings.

Reference Committee II recommends approval of this report.

VICE SPEAKER CARR: Is there any discussion of Report "E" or of the Reference Committee's recommendation?

All those in favor of Report "E" please say "aye"; opposed "no."

Report E is approved.

REPORT F

DR. STEWART: Report "F," report of the Executive Council: Recommendation that hemophilus influenza meningitis be made a reportable disease.

The Executive Council has approved the recommendation of the Committee on Child Health and Infectious Diseases that hemophilus influenza meningitis be made a reportable disease.

Reference Committee II recommends approval of this report.

VICE SPEAKER CARR: You have heard the recommendation of the Reference Committee. Is there any discussion of the report or the recommendation?

If not, we will vote on the report as presented and approved by the Reference Committee.

All those in favor say "aye"; opposed "no."

The "ayes" have it and Report F is approved and accepted.

REPORT I

DR. STEWART: Report "I," resolution regarding the delivery of primary medical care for Winston-Salem in the State. This formerly was Resolution No. 12 at the 1973 meeting.

The 1973 resolution called for a study to be made by the Council on the delivery of primary medical care. In this report, Council reports that the study made by

the Board of Governors of the University in September 1973 accomplished the purpose of the original Forsyth resolution and the Council calls our attention to the report.

Reference Committee II recommends approval of this report.

VICE SPEAKER CARR: You have heard the resolution and the report of the Reference Committee upon the resolution. Is there any discussion?

Hearing no discussion, we will vote on the report and the recommendation of the Reference Committee.

All those in favor say "aye"; those opposed "no." The "ayes" have it and Report I is adopted.

REPORT K

DR. STEWART: Report "K," a proposed position paper on the "Need for More and Better Distributed Primary Care Physicians."

Council received a proposed position paper on the need for more and better distributed primary care physicians from the Committee on Community Medical Care by Dr. John McCain acting for Dr. J. Kempton Jones.

The Council voted, one, to commend the committee for an outstanding job and, two, to publicize the paper and refer it to the House of Delegates.

Mr. Speaker, there are some 25 recommendations in this position paper all of which the Reference Committee approved. There was no statement in opposition to any of them at our meeting on the 20th.

The Reference Committee II recommends approval of this report and compliments Dr. Jones's committee and Dr. McCain's subcommittee for an excellent paper.

VICE SPEAKER CARR: You have heard the report of the Reference Committee. The Chair would call for discussion upon this, with the observation that if adopted represents the position of the House of Delegates of North Carolina Medical Society.

Is there any discussion? If not, all those in favor say "aye"; opposed "no." The "ayes" have it and the report is adopted.

DR. STEWART: We now come to the resolutions.

RESOLUTIONS NO. 1, NO. 2, NO. 3, NO. 7 AND NO. 9

We would like first to take up Resolutions No. 1 from Edgecombe-Nash, No. 2 from Scotland, No. 3 from Pitt, No. 7 from Edgecombe-Nash and No. 9 from Cleveland.

These five resolutions are concerned with repeal or opposition to the so-called PSRO law or the PSRO provisions of Public Law 92-603.

Reference Committee II considered these resolutions together at its meeting. There was lively discussion. Most of those heard favored the concept of peer review, but many had misgivings about the PSRO law.

The committee was impressed with evidence indicating, or statements indicating the futility of persuading the congress to repeal the law so far untried.

We also were impressed with statements from our delegates to the AMA that amendments to the PSRO law have brighter prospects.

Reference Committee II makes the following substitute resolution for Resolutions Nos. 1, 2, 3, 7 and 9, as follows:

RESOLVED, that although the North Carolina Medical Society strongly supports the concept of peer review having improvement of the quality of medical care as its goal, we are opposed to many aspects of PSRO legislation; and, be it further

RESOLVED, that in view of the fact that repeal of PSRO is not practicable at this time, we support the intent of the American Medical Association to have the law amended.

The committee recommends approval of this substitute resolution.

VICE SPEAKER CARR: You have heard the report of the Reference Committee.

Inasmuch as this is a consolidation of several resolutions, the consolidated substitute resolution becomes the business of the House and the main motion at this time.

Is there any discussion?

Microphone number two, Dr. Bailey!

DR. BAILEY: Mr. Speaker, I would like to request a separate vote on number one and number seven, that they be taken separately.

Number one, it would be in order to make a couple of remarks. We, in medicine, appear to be in the position of a condemned man who is afraid to offend his executioner lest we make him angry.

I think all of us recognize that PSRO is a bad law and it will decrease the level of medical care available to the population of this country and I think we are therefore obligated to oppose something which we know is bad and therefore should work for its repeal.

Even though the chances may not be good, we can still stand for what we know to be correct and things we know will help medical care in this country.

It's good at the same time to work for amendments if it's more practicable, but I think we should take the position of being for repeal of the law.

VICE SPEAKER CARR: Is there further discussion? The parliamentary situation at the moment is that there is a substitute motion offered by the Reference Committee which is the business of the House and there are two ways to handle it.

The easiest and simplest way is to defeat it if that be the will of the House, the substitute motion and address ourselves back to the original resolutions.

DR. BEDDINGFIELD: I rise to support the work of the Reference Committee and presentation of the substitute motion. I don't agree with some of the premises advanced by Dr. Bailey. There are many deficiencies or many objectionable features of the PSRO law.

I believe there is no chance whatever and I base this on, what I believe to be good authority to as recently as last week in personal discussions with members of the Finance Committee of the United States Senate which is the power structure controlling this legislation, and I would tell you very frankly there is no way this legislation can be repealed until it's a proprietary law.

I think it's an exercise in futility for this House to pass a repeal amendment.

I would further disagree with Dr. Bailey in his premise that PSRO will necessarily lead to poorer quality of medical care. Indeed, I think there's a chance it can improve medical care if PSRO is properly applied.

There are patients in North Carolina who are in an inappropriate institution, who stay an inappropriate length of time, who have inappropriate studies done on them and in an inappropriate manner.

PSRO, as judged by one's peers, would strive to correct those deficiencies.

I think it's better for us to do it than for others to do it.

I think the people who advocate repeal of PSRO must present a viable, workable alternative and under the present law, Section 249-F of Public Law 92-603, which is the Bennett PSRO amendment, if it is repealed then other portions of the Social Security Act come into play which provide for review by others who are not our peers.

I strongly support the committee's position.

VICE SPEAKER CARR: Is there further comment or discussion of the substitute motion?

DR. BAILEY: Mr. Speaker, as PSRO is written, even though peers may do the inspecting, the Secretary of Health, Education and Welfare is still the final authority.

No matter how we look at it, he's the one who makes the decisions and Dr. Beddingfield and I are certainly in basic disagreement on many parts of this and I recognize what he said is right about other parts of this overall law being more objectionable perhaps than PSRO. In that case, we should actually be opposed to the entire thing.

We are the ones who are practicing medicine, providing quality medical care, and we should be the ones who direct the progress of medicine rather than government.

All of us know, I think, that any time government gets into anything it becomes inferior. Regulation by government leads to people trying to avoid regulations and increases costs and there are many reasons I could name and I just do not want to take the time of this House to go into all of them.

VICE SPEAKER CARR: Is there further discussion?

DR. GLASSON: I would simply like to reiterate what Dr. Beddingfield has pointed out and that is in this instance repeal turns us back to already existing regulations under the Social Security Act through the Bureau of Health Insurance which all of the things PSRO can't be done other than our peers.

I would point out further that the Finance Committee and the Congress in doing this have viewed as giving doctors a chance to do peer review.

The fundamental concept is that the professional decisions are made locally by the local PSRO. As far as we have been able to see, they are sticking to this and the professional decisions regarding patient care are not, in my view, made by the Secretary of HEW.

The norms are also not made by the Secretary of HEW. They are mandatory to be made by the local peer review organization. It's a local effort and there is, as has been mentioned, a provision that in January 1976 it could indeed be done by the Secretary in designating another organization to do it.

DR. KIDD: [of Mecklenburg] I would like to have a little information that would support the intention of the AMA to have the law amended.

What are these amendments that are being offered by the American Medical Association?

DR. STEWART: At the Reference Committee meet-

ing yesterday, we were given a list of some 19 amendments which the AMA is sponsoring to be put into Congress to amend the present law.

What the status of these amendments are at the moment, I do not know. Perhaps Dr. Beddingfield could tell us.

VICE SPEAKER CARR: The Chair would recognize Dr. Beddingfield to answer a portion of Dr. Kidd's question, as is well within his province being on the AMA's subcommittee on PSRO legislation.

DR. BEDDINGFIELD: Mr. Speaker, the reason that I was asked to do this, on Wednesday of last week on behalf of the AMA I presented these amendments to the Senate Finance Committee in Washington.

The reason for this presentation was that following the AMA's clinical sessions at Anaheim last December acting under mandate of AMA House of Delegates the leadership of the AMA approached the leadership of the Congress and tried soundings on the chances of repeal and the results I have previously enunciated.

However, there are still some reasonable minds and reasonable men in Congress and in the appropriate committees that compose these, I don't mind mentioning some of these by name: Senator Talmadge, Senator Long, and a long conference was held with these men as part of the committee on finance and committee on health, and they felt if this law could be improved so that it would be tolerable, workable by physicians as they had intended, they had invited us to suggest methods and they accepted these amendments.

They were presented to them in oral and documentary form on Wednesday of last week. They are under study by the Senate Finance Committee at this time and I can report to you, unofficially, that the Secretary of HEW told me following this presentation that a good number of these amendments he thought were good and that the Secretary and the Department of HEW could support a good number of these amendments we had suggested.

So I think some of them will not have strenuous opposition.

Now, many of these are technical. If you want me to go into them I will because that really was the thrust of the question.

Maybe I could quickly glean out the more important things, if this is the pleasure of the House.

The salient features of these amendments are as follows:

The first one involves a change of definition under a section of this law so that we could perhaps have a medical society in those states having a single state PSRO without having a separate foundation set up that the Medical Society itself could become a PSRO. That is not possible under the act until after Senator Bennett leaves the Senate which is on January 1.

One of the more important amendments was a request for an extension of time past the deadline of January 1, 1976, which by the time the Congress passes the law which seems in the future, which now is a difficult task of organizing PSRO's and making them operative, it becomes more and more evident that January 1, 1976, is going to be tomorrow so an eighteen month extension of time was requested.

There is an amendment regarding the structure and form of professional participation of the National PSRO Council which is an eleven man national council

composed exclusively of physicians and it was felt that the walled intention of this was that it should be primary practicing physicians.

We have a question whether or not a practicing physician or physicians are adequately represented on the eleven man council and we have asked Congress to have oversight hearings on this and determine whether their congressional intent has been fulfilled.

There is another amendment which attempts to strengthen the fact that the norms that will be applied will indeed be norms developed within a given PSRO area, that they could use guidelines developed by others and modify them for the local situation, but that the final authority for this will be with the local PSRO.

We have asked that the law state specifically that guidelines whether they are called norms, criteria, or standards are to be guides only and cannot be substituted for individual professional judgment.

We have an amendment which would clearly exclude pre-admission certification relying instead on concurrent review after 48 hours after a patient has been admitted.

We have a provision to enunciate clearly every single case, but it does not have to be reviewed, allowing for review on a random, or sample basis, or on a constant energy basis where the probability is very evident and will be completely diagnosed.

Some of the more objectionable features of PSRO in Section 1160 provide for financial penalties. We have tried to soften this somewhat by saying a system of graduated sanctions clearly stating the maximum applicable penalties such as suspension of thirty days. He should be suspended rather than requiring a physician to reimburse the government for his patient's hospital bill when he thought he had actually been acting in good faith.

We've got another amendment.

The law presently calls for reporting by PSRO to the Secretary for certain violations on the part of individual doctors. We felt it was not the intent of the law that every single technical violation be reported and this amendment would clarify that and would require that it be reported only when a pattern of practice required such attention, or the provider practitioner has grossly, flagrantly and repeatedly violated the obligations imposed under the act.

We have an amendment to require that written records of the PSRO shall not be subject to subpoena or discovery proceedings in any civil action, a non-discoverability clause which we feel is essential to prevent a lot of dissent and professional liability litigation problems.

We have another amendment to repeal a section and to make it clearer to limit the liability of an individual furnishing items or services when such individual has acted in compliance with the norms or care applied by a PSRO, provided that he exercised due care in his conduct.

This language in the provision could have an undesirable effect of pressuring practitioners to adhere to the norms.

This provision is at best meaningless because on its face it is applicable only when the practitioner has exercised due care, so we're just asking that that be repealed.

The language I was reading would be the amend-

ment instead of the present language of the law which we're asking for that to be repealed.

There is a provision for an appeal of area designation mechanism. These are areas that have been presently designated and do not work, this provides they can go ahead and be appealed.

There's a very interesting one here, which provides for PSRO review of governmental and federal hospitals such as the VA and public health service hospitals. It's the feeling that seeing that this is for civilian population there should certainly be review of VA hospitals as well.

One of the present requirements of the law requires that PSRO inspect all hospitals within a given PSRO area. It is the feeling that hospitals are subjected almost daily to a given set of inspectors—the JCAH, Medical Care Commission, and now the Fire Marshals and so the AMA would not want on-site inspection by PSRO to be a duplication.

There is a request to repeal Section 1155 (b) (3) which would cut out a lot of paperwork for doctors and patients and to minimize such documentation.

There is a request that we seek repeal of the present utilization review procedures now under Medicaid inasmuch as PSRO would be applicable to do this.

There is another amendment that would strengthen the confidentiality portion of the law that providing information with regard to patients and with regard to activities of PSRO, review committees would not be available to agencies or arms of government.

And, that's a very brief summary.

DR. S. P. BASS, JR. [Edgecombe-Nash County]: I question whether "practicable" is the right word in there. Wouldn't it be better to say that repeal is not likely or probable rather than practicable?

Why not say likely or probable?

VICE SPEAKER CARR: It's in order, sir, to offer an amendment by deletion or addition of a word, if you wish to do so.

DR. BASS: Well, I offer the use of the word "likely."

VICE SPEAKER CARR: Is there a second to that?

DR. STEWART: We will accept that as an editorial correction.

VICE SPEAKER CARR: The Chairman of the Reference Committee states that rather than go through the process of amendment by deletion or addition, he will accept that as an editorial correction. So we will accept it.

DR. STEWART: JR. The word he wanted was what? I didn't hear it.

VICE SPEAKER CARR: "Likely."

(After considerable further discussion the question was called and the House of Delegates voted to terminate debate and vote on the previous question.)

VICE SPEAKER CARR: We will now vote on the question which is the substitute motion of the Reference Committee.

All in favor of that please say "Aye"; all opposed "No."

[There were several dissenting votes.]

The "ayes" have it unless there be reason to contest it on the part of anyone. The Reference Committee's substitute motion is passed and the resolutions to which it pertains have been adequately covered.

RESOLUTIONS NO. 4, NO. 4-A, and NO. 8

DR. STEWART: Reference Committee II would now like to consider Resolutions Nos. 4, from Pitt County, No. 4-A from Beaufort-Hyde-Martin-Tyrrell-Washington counties and Resolution No. 8 from Edgecombe-Nash.

The resolves of these three documents call for the North Carolina Medical Society to oppose the requirement of the Joint Commission on Hospital Accreditation that hospital staff privileges be delineated in minute detail.

Information was offered at our Reference Committee meeting yesterday that the Joint Commission has relented temporarily but is expected to return to the concept and make it a requirement.

Reference Committee II has consolidated Resolutions Nos. 4, 4-A and 8, substituting the following resolution:

RESOLVED, that the North Carolina Medical Society believes that hospital staff privileges should be delineated in a manner which is specific enough only to insure that the professional activities of each physician are consonant with good medical care as practiced in his medical community; and, be it further,

RESOLVED, that the North Carolina Medical Society express to the Joint Commission on Accreditation of Hospitals and to the House of Delegates of the American Medical Association its opposition to delineation of hospital staff privileges in minute detail.

The committee recommends approval of the substitute resolution.

VICE SPEAKER CARR: As stated in the foregoing question, the business before the House now is the approval or disapproval of the substitute resolution offered by the Reference Committee II.

Is there any discussion of this?

DR. DONALD B. KOONCE: [New Hanover County] I rise to speak in favor of the report of the Reference Committee but to object to what the Chairman said about the Joint Commission. The Joint Commission has not relented in its stand. Its stand has never been adamant as seems to be the understanding of the committee and it's not going to change and go back. It can't go back because it's never been there, to being adamant.

VICE SPEAKER CARR: Is there further discussion? [No response]

All those in favor of the substitute motion please say "aye"; all opposed "no."

The "ayes" have it and the resolution as amended and consolidated is approved and adopted.

RESOLUTION NO. 10

DR. STEWART: We now take up Resolution No. 10 from Cleveland County which states:

RESOLVED, that the North Carolina Medical Society request Governor Holshouser to remove chiropractors from the North Carolina Division of Health Services.

At the Reference Committee meeting, it was interesting to learn that the chiropractor appointed to the Board was appointed as a citizen and not as an individual who represents chiropractic. However, the point remains the same.

Reference Committee II amends the resolution as follows:

RESOLVED, that the North Carolina Medical Society request the present and future Governors to refrain from appointing chiropractors to the North Carolina Division of Health Services.

The committee recommends approval of this amended resolution.

VICE SPEAKER CARR: You have heard the amended resolution as offered by the Reference Committee. Is there further discussion? [No response] Hearing none, I'll call for the question.

All those in favor of the amended resolution please say "aye"; opposed "no."

The amended resolution is adopted.

RESOLUTION NO. 11

DR. STEWART: Resolution No. 11 from Anson County.

The resolution calls for the North Carolina Medical Society to work for repeal of legislation accrediting chiropractic schools or that which allows disbursement of funds of Medicare or Medicaid for chiropractic services.

Statements made at our meeting indicated that a rumor existed that if an accredited school accepted academic credits on transfer from an unaccredited school then the unaccredited school and its graduate might be made eligible for benefits otherwise not attainable.

Reference Committee II amends the resolution as follows:

RESOLVED, the North Carolina Medical Society goes on record opposing any legislation which would give recognition or accreditation to any chiropractic school; and, be it further,

RESOLVED, that the North Carolina Medical Society voice its opposition to the granting of eligibility to chiropractors or other cultists for Medicare and Medicaid funds in the performance of their services and, be it further,

RESOLVED, that the Executive Council of the North Carolina Medical Society determine whether any legally constituted educational institution in North Carolina has accepted academic transfer credits from any school of chiropractic and express our disapproval of such practices if found.

The committee recommends approval of this amended resolution.

VICE SPEAKER CARR: You have heard the amended resolution of the Reference Committee. Is there further discussion? [No response]

Hearing none, all in favor of the amended resolution please say "aye"; opposed "no."

The "ayes" have it by unanimous vote and it is adopted.

RESOLUTION NO. 12

DR. STEWART: Resolution No. 12 from Anson County.

This is concerned with the ending of the cost of living council controls and expiration of the present economic stabilization act.

Since this resolution is no longer timely, Reference Committee II recommends that this resolution be received and filed.

VICE SPEAKER CARR: You have heard the report of the Reference Committee that this resolution be received and filed.

Is there any discussion? [No response] There seems to be no discussion. We will then call for a vote.

All those in favor of filing this resolution please say "aye"; opposed "no."

The resolution is filed.

RESOLUTION NO. 13

DR. STEWART: Resolution No. 13 from Mecklenburg County. Subject is membership of the Council on Medical Education of the American Medical Association.

Statements were offered at the committee meeting that membership on the Council stands at eleven members instead of ten: one student, one private practitioner and nine medical school faculty members.

The resolution calls for more equitable membership between private practitioners and medical school faculty members.

Reference Committee II amends this resolution as follows:

RESOLVED, that the North Carolina Medical Society believes there should be more balance in the Council on Medical Education of the AMA; that it be further,

RESOLVED, that the North Carolina Medical Society proposes that the Council on Medical Education shall consist of eleven active members of whom not fewer than one nor more than five shall be full-time members of a medical school faculty; and be it further,

RESOLVED, that this resolution shall be transmitted to the House of Delegates of the American Medical Association.

Reference Committee II recommends approval of this amended resolution.

VICE SPEAKER CARR: You have heard Dr. Stewart's report for his committee. Is there any discussion of this amended resolution? [No response]

If not, all those in favor of the amended resolution please say "aye"; opposed "no."

[There were a few dissenting votes.]

The Chair rules that the "ayes" have it and the amended resolution is adopted.

RESOLUTION NO. 15

The next one, Resolution No. 15, is the one that is now being passed out to you. It was the resolution which by your affirmative vote at our first session on Sunday was accepted as a late resolution by the necessary two thirds of you. It was considered by the Reference Committee.

It may not have been read in detail other than he resolves which were presented.

DR. STEWART: Resolution No. 15 from Wilson County.

Subject: Medical Specialty Examining Boards.

WHEREAS, plans for recertification are being undertaken by many of the medical specialty examining boards, and

WHEREAS, this House of Delegates has approved the desirability of the membership of these boards being peers of those they seek to examine, and

WHEREAS, in some instances, the legal instruments setting up these boards are contrary to this concept, despite this expressed desirability, therefore, be it,

RESOLVED, that it be urged that medical specialty examining boards articles of incorporation and bylaws restrictions for membership that are contrary to the "peer" concept be removed, and be it further,

RESOLVED, that this resolution be referred to the AMA House of Delegates.

Reference Committee II recommends approval of this resolution.

VICE SPEAKER CARR: Are there further questions or discussion on this resolution which are in order inasmuch as it was a late resolution? It's in order and it is legal. [No response] Since there seems to be no discussion, we will have the usual vote.

All those in favor say "aye"; opposed "no."

The "ayes" have it and the resolution is adopted.

I would now entertain a motion for acceptance of the entire report of Reference Committee II, as amended, and before the acceptance of such a motion to thank Dr. Stewart, Dr. Hughes and Dr. Citron for their diligent performance of their quite exacting task yesterday afternoon.

[The motion was made and seconded from the floor.]

May I have an affirmative vote unanimously by saying "aye";

[Applause]

SPEAKER DAVIS: I now recognize Dr. Edward Bond, Chairman of the Committee on Messages of the President.

DR. EDWARD G. BOND [Chairman, Committee on President's Addresses]: Mr. Speaker, other Members of the Committee on the President's Addresses were Dr. Margaret McLeod of Sanford and Dr. William Romm of Moyock.

At the outset, Mr. Speaker, and Fellow Delegates, this committee would like to make it perfectly clear that we had no trouble — I repeat — no trouble at all getting transcripts of our President's spoken words— [laughter]—and with no deletions! [Laughter]

The focus of this statement, returning to the serious, does keynote the emphasis on communications that our President, George Gilbert, has so well expressed in his remarks.

As President and in his addresses, his communications have been open, grassroots in approach, "telling it like it is" and for this, we commend him and express our thanks.

In addition, President Gilbert has especially reminded us of the continuing dedication and plain, plain hard work of our headquarters staff and many of our members in their Society duties.

At no time in the past have these efforts been so needed as now. Finally, Dr. Gilbert has stressed that organized physician involvement must continue and, in fact, be an integral part of our practice of medicine if we as physicians are to meet our charge.

Mr. Speaker, it is our privilege to commend and endorse our President's Addresses and I so move.

SPEAKER DAVIS: It has been moved and seconded by Dr. Bond's committee that this report be adopted. Is there discussion? [No response]

If not, those in favor of adoption please say "aye"; opposed "no."

It is adopted with our thanks, Dr. Bond, to you and to the other members of your committee, Dr. McLeod and Dr. Romm.

The House is now ready for New Business.

I would like to take this opportunity to express what I think all of us feel and that is great satisfaction in the way that our experimental sessions in medical education proceeded both this morning and yesterday and to commend Dr. Josephine Newell and Dr. Kenneth Cosgrove who were in charge of this responsibility and whose work this really is.

I'd also like to belatedly — because I haven't had a chance earlier in the session—to thank our headquarters staff. I think all of you would agree with me that not only do we perhaps have the best staff in the country, but they could not be more cooperative and more agreeable in all the hard work that they do and I would like to have a round of applause for the good work that they do for us. [Applause]

Dr. Hughes, are you rising for New Business?

DR. JACK HUGHES [Durham County]: Mr. Speaker, I have an item of New Business concerning the exemplary administrative activities of the Speakers.

Does that require a vote or may I present that?

SPEAKER DAVIS: I think you may present that! [Laughter]

DR. HUGHES: I would move you, sir, that the House of Delegates compliment the Speaker and the Vice Speaker for another excellent performance in conducting the affairs of the House of Delegates again this year.

Further, that the House recognize Dr. Davis for a job well done during the five years he has served as Speaker of the House, particularly for his successful efforts in increasing the efficiency of the meetings of this House while increasing participation by the individual members.

[The motion was immediately severally seconded from the floor.]

[Whereupon the entire assemblage then accorded Dr. Davis a standing ovation.]

SPEAKER DAVIS: I'm sure that both Dr. Carr and I appreciate that more than you realize and as this is my "Swan Song," I particularly appreciate it and would like to take just a moment to express to this House my sincere appreciation for what I consider a real privilege for having served as your Speaker.

As I trust you know, this has been a very stimulating and rewarding experience for me and I think you know it has been fun all the way, even when Shaffner gets up to object to every ruling—[laughter]—and Beddingfield skims in at the last minute and that boy never misses a deadline—[laughter].

It has been fun and I am most grateful to you. You have been most courteous, most kind and I appreciate your helpful cooperation.

I need not emphasize what great help Dr. Chalmers Carr has been throughout this five year tenure. This House, I think as all of you realize, is a truly great institution and it can only get greater.

You have chosen your new Speaker and your new Vice Speaker exceedingly well.

In these days of energy shortage, you have taken care of everything. You have two Carrs—you've got a big Carr and you've got a little Carr!! [Laughter]

And, certainly, they can only succeed and I wish them well. I thank you for all the help you have given me and I now turn the podium over to your Speaker, Dr. Chalmers Carr, for adjournment. [Applause]

SPEAKER CARR: I wish to personally thank Dr. Davis—Jim, as I've known him for many years—for showing me the ropes of this office which I have enjoyed, and I hope that I shall be able to carry it on in the tradition which he has established.

I have no prepared speech, nor shall I make one now. I'm in the position of saying that since you have chosen a Vice Speaker who happens to have my same surname, though we would have to go way back into the roots of Duplin County to find a cross connection, but I'm sure there's one somewhere as my paternal ancestors originated in Duplin County from which he comes.

With that, we adjourn the House.

[The meeting adjourned at four-ten o'clock.]

President's Dinner

TUESDAY EVENING SESSION

May 21, 1974

The President's Dinner Meeting of the 120th Annual Meeting of the North Carolina Medical Society convened at nine o'clock in the Main Dining Room of the Pinehurst Hotel, Pinehurst, North Carolina, Dr. James E. Davis, Speaker of the House of Delegates of the Society, acting as Master of Ceremonies.

MASTER OF CEREMONIES: Will the House please come to order? [Laughter] Will the House please be in order? [Laughter]

I'm sorry, it must be a habit!

This is really the President's Dinner and right away want to put you at ease because I know you're sitting back there with your tiny little heads saying, "What is he doing up there tonight?"

You know I'm not George Gilbert and you know and know I'm not President—but I'm working on it! [Laughter] And, I'll tell you the reason I'm here is simply because we've got a very kind and considerate President.

It's sort of like this—shortly after I was impeached this afternoon by the House of Delegates—[laughter]—and George came by and said, "Yes, I think I can understand because tomorrow I'm going to be in the same boat!", but he said, "I think I can help you out with a temporary job if you can work tonight!" [Laughter]

So I'm here to welcome you here tonight to Katie and George Gilbert's Presidential Dinner.

First of all, I would like to present to you those sitting at the head table and I'll ask you to withhold your applause until all have been recognized.

On my far right are Dr. and Mrs. Elliott Dixon; Betty of course is the President of the Women's Auxiliary and Elliott has been Chairman of the Nominating Committee.

Next is Ella Glasson, of course the wife of our immediate Past President, John Glasson.

And, next is Katie Gilbert and I will ask her not to rise if you will.

And, on my far left Margaret Hilliard, wife of course of our Executive Director, Bill Hilliard.

Next, Mrs. Russell Roth and Dr. Roth the President of the American Medical Association, whom we will hear from tomorrow.

And, next, Marguerite Reynolds, wife of our incoming President.

And, then the most important person here, the most valuable player received in my league, my wife, Margaret.

[As the Master of Ceremonies introduced each person, they stood to be recognized and were applauded by the audience at the conclusion of the introductions.]

We have so many other dignitaries seated throughout the hall that I would not attempt to recognize all of them, but we're particularly glad to have with us tonight one of George Gilbert's associates and I'll ask Dr. George Coughlin and his lovely wife, Jean, to please stand.

Mrs. Ruth Scrivner, the President of the National Auxiliary is with us. We regret that Dr. Scrivner could

not be here. He is a Past President of the Illinois State Medical Society and is also a member of the PSRO Advisory Committee. Mrs. Scrivner, we're delighted to have you with us.

And, also, Dr. Ed. Annis, a Past President of the American Medical Association, whom we will also hear from tomorrow morning.

[As each of the additional persons were recognized, they stood at their place in the audience and were applauded at the conclusion of the introductions.]

I think you will all agree that George Gilbert has run a very tight ship this year, has had a very thorough, far-reaching administration. In fact, this morning he pointed out to us in his Presidential Address all the innovations he has brought about. He has enlarged the staff. He has shuffled them around. He has raised all the salaries. He's after the "bad apples" in the membership and it was only after my experience with the House of Delegates this afternoon that I found out what he meant by "bad apples"! [Laughter] He certainly got rid of me in a hurry! [Laughter].

But in his retinue is something that other past Presidents have not had — King George had a court jester, if you will, through the year and I will now recognize Josephine Newell—[laughter] — to please come and pay her final respects to King George of Gilbert!

[Applause] [Cheers]

DR. JOSEPHINE E. NEWELL: Dear friends! [Laughter]

Everybody knows that Jim is desperate!

I'll tell you what's the truth, you look in your folders you'll see I'm listed for Moderator tomorrow and the day they told me I was the moderator—there I am in print—they said, "The great dignitaries from the AMA, Dr. Annis and Dr. Roth, and Jo we know we've got some explaining to give to the AMA"—[laughter] but I want to tell you that I love 'em all, every one of you, and particularly George Gilbert; George Gaylord Gilbert.

And, I was thinking about that as I was walking up here, just a few short seconds, he's the gayest lord I've ever seen in my life! [Laughter]

But, LaRue King told me that "gay" meant something else all together and I didn't even know it—[laughter] O Lord!

You know, they sic her on me day and night and tell her, "Watch her! Don't let her say anything out of place!" By golly, and she watches me.

They send me to the AMA meeting to pick up the scientific exhibits and they said, "You've got to live in a room with LaRue and she'll watch you like a hawk!" and she does! [Laughter]

But I did want to tell you this, that one of the greatest experiences of my life has been this year when Katie Gilbert has tried and has gone every time and joined George in his escapades all over the United States and everywhere else he has gone, in spite of a broken hip and her other infirmities.

She has been really the First Lady of the Land and

I ask you for your applause for Katie, the great lady!

[Applause]

For George, for Frank Reynolds to whom we are going to be greatly indebted—we're already indebted but he's going to be one of the greatest Presidents we've ever known—in our fight for private enterprise and for personal endeavors.

I can be serious at times and I am serious. I have to make a living, just like the rest of you fellows! [Laughter] Ain't nobody going to buy bread for me when I get home! I just have to get out and make it and I have to make it just like you do and I do appreciate this and I do want to render a service, just as you do.

And, I am opposed to all this socialized stuff and I am working with you and for you.

And, the thing is, nobody can tell me about Women's Liberation. You don't have to be liberated. All you have to do is work with those men and stand your ground and they'll help you stand it and you can help them stand theirs: we're all working for one common thing—the best thing for American medicine and American health.

And, that's what these three great fellows are fighting for — George Gilbert, Frank Reynolds and Jim Davis and all of the AMA and I ask your support and thank you so kindly for putting up with me.

I admire every last one of you. You're great fellows. You've always produced great presidents. They have produced for you and these are three of the greatest! And, thank you so much. [Applause]

MASTER OF CEREMONIES: As always, Josephine Newell!

George has agreed to work some this evening and at this point he is slated to install the newly elected officers and so I will ask the First Vice President-elect, Dr. Hughes; Second Vice President-elect, Dr. Sohmer; the Speaker and the Vice Speaker, the Carr boys, to please come forward and the President will administer the oath of office.

[Whereupon the newly elected officers then came forward to the podium.]

PRESIDENT GILBERT: I should mention that our esteemed Master of Ceremonies is also President-elect and he's going to get sworn in too, whether he likes it or not.

Repeat after me, this oath of office.

[Whereupon each newly elected officer then repeated his oath of office as President Gilbert recited:]

I SOLEMNLY SWEAR THAT I WILL CARRY OUT THE DUTIES OF MY OFFICE TO THE BEST OF MY ABILITY. I SHALL UPHOLD THE CONSTITUTION OF THE UNITED STATES OF AMERICA AND THE CONSTITUTION AND BYLAWS OF THE NORTH CAROLINA MEDICAL SOCIETY AT ALL TIMES. I SHALL CHAMPION THE CAUSE OF FREEDOM IN MEDICAL PRACTICE AND FREEDOM FOR ALL MY FELLOW AMERICANS.

What Say You?

[Whereupon the newly elected officers responded in unison.]

I Do!

MASTER OF CEREMONIES: I now recognize John Glasson, immediate Past President.

DR. JOHN GLASSON: Thank you, Mr. President-elect.

Distinguished Guests of the Society, Dr. Roth, Dr. Gilbert, Ladies and Gentlemen:

It has been my privilege to work very closely with George Gilbert in the work of the Society for the past ten years and as tradition would have it, it is my privilege at this time to share with you some of the observations and experiences which do not always come into the spotlight in connection with the official meetings and functions of the Society.

George Gilbert's official biography is in the program of the meeting. Additional facets of his life are familiar to many of you and to others, perhaps not.

No man was ever more conscientious, devoted to duty, or more effective as a professional man, as a leader in organized medicine and, indeed, as President of the North Carolina Medical Society, than George Gilbert.

When the month of July rolls around, however, as surely as the swallows go back to Capistrano, George Gilbert and his family retreat to the family summer place in the mountains of New England, where, after some forty years, they are beginning to get almost or speaking terms with some of the true natives of this area.

Many years of exposure to these fine people and to the fine people of the mountains of Western North Carolina tend to mold even a person with the strong character of this minister's son into a rugged individualist who is honest to a fault.

George tempers his honesty with kindness on all occasions, but without too much prompting if he is at all goaded by his friends, me included, he will come out with such things as, "Go to (expletive deleted), John!"

[Laughter]

Whereupon he will calmly resume the topic of conversation or will resume one of literally thousands of good stories which he has at his command, many of which as you can well imagine, are related to his field of primary professional endeavor as a urologist.

He spends more time by far than the average doctor talking with his patients on a one-to-one basis evaluating their opinion on the broad subjects of delivery of health care, insurance and other items of general interest to all American citizens.

He has used all types of air transportation covering the breadth of the good state of North Carolina in connection with his assigned duties as a leader in the North Carolina Medical Society and his early training as a pilot has enabled him on some of these occasions to take a turn at the controls.

As one might expect from a native of the North Carolina mountains, he has a healthy and somewhat suspicious respect for all "revenooers" and Feds, under whatever guise! [Laughter]

Like all Presidents of our Society, his commitment to this job has also been a commitment shared with the other members of his professional partnership and he never fails to recognize the contribution which they make in behalf of the work of organized medicine in our state through their sponsorship of his participation in this important work.

As I noted last year, George came through Hopkins with many of the giants of American medicine today and like Russell Roth, our honored guest, Rollins Hanlon, and as he says, Willie Longmire and others who

ere his classmates. He is evolving as a giant in his own right though he would, I am sure, view this statement with obvious disgust and great reservation.

I am sure you have all enjoyed with me the smooth, honest, sincere and conversational style of his writing in the monthly President's Newsletter this year.

For me, his effort in this publication has been one of constant concern for the timely presentation of current legislation, federal regulations and, as he expresses it, whatever has been the latest thing to hit the fan—

le brings to us his greeting.

It's the "Doc from the hills" who brings us the thrills at the Annual Medical Meeting.

He can stop all pollution, he can solve distribution as he travels by plane or by Hertz.

He deciphers the role of Price Control to keep it from driving us "Nertz."

He is truly the Scion from Buncombe to Tryon as he works out the guides with the "Blues" from Raleigh to Sidney, it's our Captain Kidney who will stop the next raise in the "dues."

As he flies like an eagle, he is handsome and regal as he has a firm hand at the helm.

Whether it's problems of health or the spread of the wealth, he is known throughout all the realm.

He's the son of a preacher and he's known as a teacher as he can handle a pain in the flank.

He will bring you new hope with his trusty old scope or in this he is rated "Top Rank."

[laughter]—which is important to his fellow North Carolina physicians.

So, George, before you turn over your responsibilities to Frank Reynolds, we would ask you to hear this little poem by an anonymous author:

It's called:

CAPTAIN KIDNEY

For our President here, the man of the year we gather to honor tonight.

He turns gloom into cheer, he leads without fear as he gives all those feds a real fright.

From the old North State the Watergate

Will make us all wiser but sadder.

Go to George at the Mission, assume the position and "Presto" you'll have a new bladder.

He can start a Foundation, he can clean up the Nation as we tool up for PSRO;

Fix the Medicare forms or develop the Norms as our big man puts on quite a show.

He is the "Pilot at the Wheel," he carries on with lots of zeal,

With faultless propriety, he leads the Society whether it's reading a tough I.V.P.,

Reading the Blips or washing out chips as his performance is something to see.

Now—expletive deleted—as is oft-times repeated, he's a master behind any "mike"

For a union physician he takes the position
You can fuss, but you didn't not strike.

He promotes legislation to require education
And for us all he made it a rule
That we accomplish a pass in a medical class
Or get ourselves back to the school.

For the states and possessions, he leads the "Profession,"
He has solved all our problems with fuel.
There can be little doubt as you start to go out
That he really deserves this fair "Jewel"!

George, here it is!

[Whereupon Dr. Glasson then pinned on the President's Jewel to Dr. Gilbert's coat lapel.] [Applause]

PRESIDENT GILBERT: I just said, "You — expletive deleted!" [Laughter]

It is now my duty, probably the most enjoyable duty I've had all year now that I think of it, to swear in my successor, so Dr. Frank R. Reynolds, please come to the podium.

[Whereupon as President Gilbert recited the oath of office of the President, Dr. Reynolds repeated it after him as follows:]

I, FRANK REYNOLDS, SOLEMNLY SWEAR THAT I SHALL CARRY OUT THE DUTIES OF THE OFFICE OF PRESIDENT OF THE NORTH CAROLINA MEDICAL SOCIETY TO THE BEST OF MY ABILITY. I SHALL STRIVE CONSTANTLY TO MAINTAIN THE ETHICS OF THE MEDICAL PROFESSION AND TO PROMOTE THE PUBLIC HEALTH AND WELFARE. I SHALL DEDICATE MYSELF AND MY OFFICE TO IMPROVING THE HEALTH STANDARDS OF THE AMERICAN PEOPLE AND TO THE TASK OF BRINGING INCREASINGLY IMPROVED MEDICAL CARE WITHIN THE REACH OF EVERY CITIZEN. I SHALL UPHOLD THE CONSTITUTION OF THE UNITED STATES AND THE CONSTITUTION AND BYLAWS OF THE NORTH CAROLINA MEDICAL SOCIETY AT ALL TIMES. I SHALL CHAMPION THE CAUSE OF FREEDOM IN MEDICAL PRACTICE AND FREEDOM FOR ALL MY FELLOW AMERICANS.

I SOLEMNLY SWEAR THAT I WILL DISCHARGE THE DUTIES OF OFFICE TO THE BEST OF MY ABILITY. SO HELP ME GOD.

[Whereupon the entire assemblage then accorded newly elected President Reynolds a standing ovation.]

PRESIDENT REYNOLDS: The buck stops here! [Laughter]

Dr. Roth, Dr. Annis, Distinguished Guests:

I do consider this the highest honor that our Society can bestow on any of its members. I realize fully that one cannot accept this honor without also accepting the responsibilities that accompany it.

Our Society has been extremely fortunate in the past in having leaders with dedication, ability and stature and I shall try to follow in their footsteps.

As you noticed on the program, fortunately, there's not an acceptance speech, just acceptance "remarks," so if you'll bear with me for a few minutes I just have a few remarks I'd like to make.

First, about the only difference I noticed in getting

older is, first, that one appreciates the family more, second, one appreciates their friends a great deal more and, thirdly, one gets more garrulous! [Laughter]

With this in mind, I would like to take this opportunity to introduce my family to you.

All of you know my long-suffering wife, Marguerite! I would like to introduce my children to you.

Our oldest son, Frank, Jr., is working for the Health Department down in South Carolina and he had to go to an EPA meeting of all things in Atlanta, so he couldn't get here.

But my oldest daughter, Margo!

My next daughter, Lindsey, who will be a freshman at St. Mary's next year!

And, my second son, Fairfax, who will be a senior in premed at Chapel Hill this year.

[Whereupon each member stood as he or she was introduced, following which their recognition was applauded.]

Now, secondly, I would like to thank all of Marguerite's and my friends who have come to Pinehurst for this occasion. I want them all to know that we appreciate it more than they will ever know.

When I look around I see a great many of them from home and it really has meant a lot to me to see them here tonight.

The last thing, if you could bear with me a few moments, I just have a few words I'd like to say.

A lot of my friends and other people have said, "Frank, how in the world have you been interested in the Medical Society for so long? How can a pediatrician down there on the coast get up to Raleigh?" My only answer to them has been that I've been extremely fortunate in having very, very dedicated friends.

It all started back in 1957 when we had a very special

man from Wilmington who was President of the State Medical Society, Dr. Donald Koonce. [Applause]

Dr. Koonce asked me if I would work and I told him, yes, I certainly would, so he put me on the Legislative Committee. Then I had several trips to Washington with them and then when they had a meeting at Pinehurst, Donald would call and say, "Come on, Frank, let's go to Pinehurst!" and I would say, "All right!"

I was also fortunate when I got up here, I had the opportunity of playing golf with some of Donald's friends. If any of you have ever played golf with "Pot" Poteat and Charlie Styron and Alfred Hamilton and some of those, it's worth the price of admission up here just to hear them! [Laughter]

So, anyway, buddy, it seems to me that every time that I would get a little slack or something, Donald was always there and anything about the State Medical Society you could always ask him. I don't know anybody who knows any more about medicine in North Carolina than Donald Koonce and I would just like to say that if it wasn't for Donald, I don't think I would be here tonight. I certainly appreciate it.

The other thing, if you noticed on your program after we leave here, the President's Ball is over in the Cardinal Ballroom and I want to tell all of you that we certainly do appreciate your coming and as you leave here, if we adjourn, and go right down the hall the orchestra is going to start playing and we want to assure you that the party is just starting! Thank you again.

[Applause]

MASTER OF CEREMONIES: Have a nice evening! We stand adjourned. Good night!

[The meeting adjourned at nine-thirty o'clock.]

General Sessions

MONDAY MORNING SESSION

May 20, 1974

The First General Session of the 120th Annual Meeting of the North Carolina Medical Society convened at nine-five o'clock in the Cardinal Ballroom of the Pinehurst Hotel, Pinehurst, North Carolina, Dr. George G. Gilbert, President of the Medical Society, presiding.

PRESIDENT GILBERT: Would everybody that's going to come to this session come on down on the floor and have a seat up front, preferably, so we can get this show on the road!

Well, I believe it is up to me to initiate the ceremony for the first general session of this, the 120th meeting of the State Medical Society. So, with this, I will introduce our Moderator who is Chairman of the Department of Surgery at the University of North Carolina. These good people have gone to great trouble to prepare their papers which I'm sure will be fabulous and I think we're all going to learn an awful lot. Thank you for coming.

DR. COLIN G. THOMAS, JR. [Professor and Chairman of the Department of Surgery, University of North Carolina School of Medicine, Chapel Hill, N. C.]: Let me thank you all for being here. I'd like to introduce our Dean, Christopher C. Fordham, III, who will have a few comments to make.

DR. CHRISTOPHER C. FORDHAM, III [Dean, UNC School of Medicine, Chapel Hill]: Mr. Chairman, Mr. President, Fellow Members and Guests: It's a pleasure to participate in this program and comment on the new format. I hope it will prove to be successful. We are certainly pleased that our Department of Surgery is beginning the general sessions this year in the new format.

There are important new trends in medicine. I thought I might spend a minute before we start the formal program addressing a few comments to the role of the surgeon and the surgical sub-specialist in some of these new trends because I believe the surgeon has a critical role to play and it may not appear that at the surface.

One of the important new trends in medicine and medical practice, medical education, is the great emphasis in our society now along more generalists, more primary care physicians; physicians trained in family medicine, general internal medicine, general pediatrics, and I think it's very clear, judging from what's happening all across the country and in the State of North Carolina, that this trend is with us.

That the trend in a sense swims against the natural evolution of specialization when knowledge and technology burgeon as they have in the medical field.

In other fields, specialization is the inevitable consequence of the growth of knowledge, but it's very clear that in our society there is a cry among governmental agencies, professional groups and the general public for better accessibility to comprehensive care embodied in the primary care physician.

What's the role of the surgeon in this changing scene?

It's quite likely as we see medical schools grow and graduating classes from medical schools grow, we're going to see an increasing proportion of those gradu-

ates going into primary care specialties and not into the sub-specialties of medicine and surgery.

So there will be proportionately fewer surgeons coming from the expanding generation of medical students.

I would present the thesis that the surgeon nevertheless has an important role to play.

We have in the State of North Carolina embarked upon a major new effort—the profession of medicine, the medical schools, the State of North Carolina, the Board of Governors — to make health education as fully responsive to serving the needs of the state as it can possibly be.

And, this is exemplified with the Area Health Education Center Program which I talked about in this forum last year and will not belabor this morning.

It does address itself to several of the key problems in our state, the number of physicians, the distribution geographically, and a key part of it is the distribution of physicians in our state by specialty with the major emphasis and the major thrust in the primary care field.

As we proceed attempting to mount these residencies, working with our colleagues in practice, in hospitals across the state, several critical items need attention and deserve attention which I think perhaps haven't had a sufficiently careful analysis in our country.

One of the difficulties is that we're such a large country and the states and the variations within the states are so great in terms of health care needs.

But, North Carolina is an entity with a responsibility and it just may be possible for us to come up with a rational approach to improving access to services.

Now, the issues to which I refer have to do first with some kind of effort to define the content of the practice of medicine, that is the generalist practice of medicine in the future, based on an analysis of the clinical problems which come to the physician.

I believe this is an effort which has not been satisfactorily accomplished in our society and it must be a joint effort: it must be an effort between the academic medicine, the organized practice of medicine including the surgeons and the surgical sub-specialists, the medical sub-specialists and those who plan to be generalists and those who are now serving as generalists.

I do believe that the glamor and the additional prerequisites and esteem and prestige issues are pretty much behind us, so that we can look upon all trainees as in fields of worthy endeavor. The pay differentials under the VA and the military no longer exist and so it's not a matter of what's better than something else. It's really a matter of how do we train men and women to each kind of practices they want to do and that's needed in given areas of our state.

So for example, the orthopaedic surgeon needs to help us define what the generalist can properly do in a setting in the State of North Carolina that will not compromise the outcome to the patient.

Should the generalist, for example, set a Colles fracture?

I think we need to do a lot of work on this matter

of content of practice and we need to do it together.

Secondly, arising from this analysis should be an improvement in our training programs for generalist physicians.

We only have three years at the present time to train a family physician, for example. Many people have commented that the family physician needs to be trained much longer than many of the sub-specialists because of the breadth of his challenge. Therefore, we must make that three year training program as effective as possible.

Teach that trainee what he or she needs to know and not spend a lot of time teaching things that he or she will not be doing except insofar as they contribute to the total capability.

But we need to use that time well.

And, thirdly, we need to articulate these training programs and this definition of clinical content with the assured specialty backup across the State of North Carolina in those areas where the generalist is not trained in special techniques and capabilities and so on.

Now, I would simply conclude by saying that the surgeon has a very important role to play in the changing scene. I think it's clear that the Department of Surgery at Chapel Hill is very concerned about the training of future generalists, their own role in this and I'm very pleased with their approach to it. We've got a long ways to go to deal effectively with the issues and translate them into training programs.

This collaborative effort though with the profession is, I think, just one area of an example where the medical schools and the organized profession are growing closer together in dealing with the problems that we face and the understanding of the public of our efforts to serve them and our own understanding of what they view their problems to be.

We've had that experience in developing our affiliated hospital programs, our associated hospital programs now, our care of individual patients from all hundred counties each year that goes by and the development of the exciting new area health education centers program this year, which the General Assembly as you know, has generously funded. The partnership that we have, though, with the practicing profession is critical if we're to solve these problems.

The medical schools certainly can't do it, but they can help the profession do it and in this vein I want to pay special thanks to the leadership of the Society in the past several years. I'll only go back to the year before last when Dr. John Glasson was President, to this year with Dr. George Gilbert, and look forward to next year with Dr. Frank Reynolds.

We certainly have had a very close relationship and the constituent societies within the Medical Society have been of inestimable value in working with us to develop teaching programs out of the state.

Finally, I'd like to make a couple of comments and express a few words of appreciation to my colleagues in the Department of Surgery who will be delivering the more formal part of this program.

To Dr. Thomas, the Chairman, to Dr. Murray, Dr. Fagelman, Dr. Croom, Dr. Biggers, Dr. Bevin, Dr. Preston, Dr. Avis who will be giving the talk originally scheduled for Dr. Cole, Dr. McDevitt and Dr. Mandel.

This is a mixture of junior and senior faculty of great capability and dedication.

As we all know but need perhaps to be reminded on occasion, the academic surgeon like his community based counterpart is a very special kind of individual. Even in the teaching setting, dedication to patient care must come first on his list.

The teaching surgeon functions as a multiplier by serving as an example, as well as teaching by precept and he also has responsibility for the advancement of knowledge, understanding and skill in the surgical care of patients.

Our surgeons are dedicated to the State, to the University Medical School, but most of all to their patients and their trainees. On all these counts, I believe my colleagues merit high marks and I'm grateful to be associated with them.

I conclude by saying how much I appreciate the privilege of opening this session and of working with the Society as a member.

MODERATOR: Thank you, Dean. Mr. President, Members and Guests:

The Department of Surgery is honored and delighted to have this opportunity to present to you the topic of "Contemporary Surgical Management."

Our objectives are to bring to you some recent advances in surgery covering common medical problems that, hopefully, will provide you with a better understanding of the type of care that is available and indications for its application.

This knowledge should, directly or indirectly, enable you to provide better care for your own patients. As Dean Fordham has mentioned, you'll notice that our faculty that we've selected are relatively young.

They're in the forefront of medicine. They're imaginative, critical thinkers with a high degree of intellectual curiosity. They're not willing to accept the imperic approaches of the past.

All of them, as has been indicated, are involved in active care of patients, the teaching of our medical students and house staff, as well as conducting investigative programs.

Although we have no formal question and answer period, perhaps at the end of each individual's presentation, if there's time, we can entertain one or two questions.

In presenting new information, I'm reminded of the comments of a speaker at a graduating medical class indicating that he had both good news and bad news for the graduates.

The good news was that despite the rapid advances in medical knowledge, at least half the information that they had been presented with was absolutely true.

The bad news was that each wasn't sure which half!

Now, today we're going to present you with the half that is true and will remain so.

Our first speaker is Dr. Gordon Murray, Assistant Professor of Surgery of the Division of Cardiovascular and Thoracic Surgery.

Dr. Murray is a graduate of the University of Michigan and joined us two years ago after completing his graduate education in surgery at Johns Hopkins.

Dr. Murray's topic is "Cancer of the Lung."

DR. GORDON F. MURRAY [Assistant Professor of Surgery, Division of Cardiovascular and Thoracic

Surgery, UNC School of Medicine, Chapel Hill, N. C.):

[Whereupon Dr. Murray presented his paper which will be submitted to the *North Carolina Medical Journal* for possible publication.]

MODERATOR: Our next speaker is Dr. Fredric Fagelman, Assistant Professor of Surgery in our Division of Neurosurgery.

Dr. Fagelman is a graduate of the University of Vermont and he continued his graduate education in surgery and neurosurgery at the University of Vermont.

This is his first year on our staff.

Neurosurgeons as you know have for a long time been interested in pain control which is one of his topics. He is also going to bring to us some of the newer aspects of micro-neurosurgery.

DR. FREDRIC I. FAGELMAN [Assistant Professor of Surgery, Division of Neurosurgery, UNC School of Medicine, Chapel Hill N. C.):

[Whereupon Dr. Fagelman presented his paper which will be submitted to the *North Carolina Medical Journal* for possible publication.]

MODERATOR: Our next speaker is Dr. Robert D. Croom, III. Dr. Croom is one of our own graduates, having finished at Chapel Hill several years ago with his subsequent graduate education at Johns Hopkins, North Carolina Memorial Hospital and Walter Reed.

He has been a member of the general surgical staff for two years.

Dr. Croom brings to us a topic, I think, which does represent a real advance in medicine and has application in both medicine and surgery. The topic, "Improved Nutrition — Parenteral Alimentation and Elemental Diet."

DR. ROBERT D. CROOM, III [Assistant Professor of General Surgery, UNC School of Medicine, Chapel Hill, N. C.):

[Whereupon Dr. Croom presented his paper which will be submitted to the *North Carolina Medical Journal* for possible publication.]

MODERATOR: Our next speaker is Dr. Paul Biggers, Associate Professor of Surgery in our Division of Otolaryngology.

All of us I think have been concerned about the inability to communicate defining extirpational surgery and other more subtle injuries to the larynx.

Dr. Biggers today will bring us the exciting topic of "Surgical Restoration of the Voice."

DR. W. PAUL BIGGERS [Associate Professor of Surgery, Division of Otolaryngology, UNC School of Medicine, Chapel Hill, N. C.):

[Whereupon Dr. Biggers presented his paper which will be submitted to the *North Carolina Medical Journal* for possible publication.]

MODERATOR: The next speaker is Dr. A. G. Bevin, Associate Professor of Surgery in our Division of Plastic Surgery.

Dr. Bevin is a graduate of Yale and continued his graduate education in surgery at Yale and the Department of Surgery at UNC.

His topic today is "Treatment of the Burn Injury."

DR. A. G. BEVIN, JR. [Associate Professor of Surgery, Division of Plastic Surgery, UNC School of Medicine, Chapel Hill, N. C.):

[Whereupon Dr. Bevin presented his paper which

will be submitted to the *North Carolina Medical Journal* for possible publication.]

MODERATOR: I'd like to introduce the next speaker, Dr. Edwin Preston, Associate Professor of Surgery and Orthopaedic Surgery.

Dr. Preston is a Duke graduate and had his subsequent graduate education in surgery at the Children's Hospital in Boston and The Brigham.

He has been on our staff in the Division of Orthopaedic Surgery since 1969 and will bring new developments in Orthopaedic Surgery.

DR. EDWIN T. PRESTON [Assistant Professor of Surgery and Orthopaedic Surgery, Division of Orthopaedic Surgery, UNC Medical School, Chapel Hill, N. C.):

[Whereupon Dr. Preston presented his paper which will be submitted to the *North Carolina Medical Journal* for possible publication.]

MODERATOR: The next speaker is Dr. Fred Avis, who is a graduate of the University of North Carolina School of Medicine and continued his education in surgery.

During his second year as a surgical resident he was in the tumor clinic and developed a keen interest in tumor immunology.

He has pursued that now a couple of years in the laboratory and will be joining us next year as a current member of the staff.

Dr. Avis will speak on "Immunological Advances in Urological Tumors."

DR. FRED AVIS [Instructor, Department of Surgery, UNC School of Medicine, Chapel Hill, N. C.):

[Whereupon Dr. Avis presented his paper which will be submitted to the *North Carolina Medical Journal* for possible publication.]

MODERATOR: The next speaker is Dr. Noel McDevitt who again is a graduate of the University of North Carolina and continued with his graduate surgical education in our Department of Surgery.

He joined us this year as an Assistant Professor of Surgery in the Division of Vascular Surgery.

It has always impressed me that with the availability to provide new techniques and in this instance restore blood flow, how many patient problems we then see, and obviously there's a need to evaluate peripheral blood flow and Dr. McDevitt is going to bring to us today, a "Non-Invasive Estimate of Peripheral Blood Flow."

DR. NOEL B. McDEVITT [Assistant Professor of Surgery, Division of Vascular Surgery, UNC School of Medicine, Chapel Hill, N. C.):

[Whereupon Dr. McDevitt presented his paper which will be submitted to the *North Carolina Medical Journal* for possible publication.]

MODERATOR: Our final speaker is Dr. Stanley Mandel, Associate Professor of Surgery, again in the Division of Vascular Surgery, Trauma and Transplantation.

Dr. Mandel is a graduate of the University of Virginia and had his graduate education at Duke and also the University of Virginia.

He has been on our staff since 1969 and has had an interest in transplantation. He brings to us the role of the community hospital in end stage renal disease.

DR. STANLEY R. MANDEL [Associate Professor of Surgery, Division of Vascular Surgery, UNC School of Medicine, Chapel Hill, N. C.):

[Whereupon Dr. Mandel presented his paper which will be submitted to the *North Carolina Medical Journal* for possible publication.]

MODERATOR: Dr. Cosgrove has advised me that we may all receive five hours of continuing education credit for this session.

I'd like to thank the audience for being so patient and staying beyond the scheduled time and, hopefully, we have presented something to you that will be of some help in your patient management. I think Dr. Gilbert would like to make a few comments before closing.

PRESIDENT GILBERT: First of all, as I mentioned at the beginning, with this innovation, I think you've all seen that this program has been fabulous and I think a tremendous success and we sure want to thank Dr. Thomas and his colleagues from the University of North Carolina School of Medicine for making this presentation.

I think all this augurs well for our future, gentlemen, as far as general sessions.

[The meeting adjourned at twelve-thirty o'clock.]

TUESDAY MORNING SESSION

May 21, 1974

The Second General Session of the 120th Annual Meeting of the North Carolina Medical Society convened at nine-ten o'clock, Dr. D. E. Ward, Jr., First Vice President of the Medical Society, presiding.

CHAIRMAN WARD: Good morning.

I want to welcome you to the Second General Session of the North Carolina Medical Society meeting.

Today, it's my pleasure to act as presiding officer for the Medical Session which is the Bowman Gray Medical Session Program put on by the faculty of the Bowman Gray School of Medicine.

This morning I'd like to introduce to you the Dean of Bowman Gray School of Medicine, Dr. Richard Janeway, and in turn, Dr. Janeway will introduce to you Dr. Joseph Johnson, Professor and Chairman of the Department of Medicine, who, will in turn, introduce his own faculty members who are on the program this morning.

Dr. Janeway was born and reared in California, attending Colgate University and graduated from the University of Pennsylvania School of Medicine and I interned at Philadelphia General which is just over a stone wall from Pennsylvania and up there all these men are referred to being at THE university, just like there was no other one in the country and all of us at Philadelphia General always sort of ganged up at the university graduates when they started coming out with this business of THE university, but it is referred to as THE university up in Pennsylvania.

He took his graduate education as a Public Health Fellow in Research Pathology, interned at the University of Pennsylvania, also at School of Aerospace Medicine in Texas and came to North Carolina as a resident in neurology at the Baptist Hospital.

From here he was appointed to the faculty and was first a neurologist and then he did such a good job in this hard and complicated field, they decided that he would make a good dean, so they took him out of neurology and they made him Dean of the Bowman Gray School of Medicine.

He is certified by the American Board of Psychiatry and Neurology and if he limps when he comes up here, it is not that he was wounded in the line of action as the dean, it was a wound received legitimately not jumping out of a second story window but on a tennis court running back to get a lob and he pulled a ligament in his leg so he has a cast.

DR. RICHARD JANEWAY [Dean, Bowman Gray School of Medicine, Winston-Salem, N. C.]:

I found out I was one year older and one step slower on the tennis court and I guess it's been that kind of a year.

I very much appreciate your attendance for this brief introduction to "What's New at Bowman Gray" and there's a great deal that is new as well as a great bit that is old and traditionally present.

The class size had just gone from 46 to 54 when I arrived in Winston-Salem in 1963. We will enter 89 students this September and in cooperation with the state, approximately 98 students in 1975 entering class.

Perhaps the newest thing at Bowman Gray, after prolonged discussion among the faculty at our retreat that we have at Pottstown, West Virginia, last June and then with a formal vote of the faculty executive council on Friday, the Department of Family Practice was established at the Bowman Gray School of Medicine as an academic department of the institution.

One of our new people who is heading up the Department of Medicine has been with us since October of 1972. He's Dr. Joe Johnson who comes to us via Vanderbilt where he received his undergraduate medical training and then to the Hopkins for residency training and then was at the University of Florida Gainesville as head of the Section of Infectious Disease and Professor of Medicine there.

He has now been with us approximately a year and a half, has a very strong Department of Medicine, in the process of continuing growth and we would anticipate that it will approximately be 1-3/4 going on twice the size of what it was when Joe came to us in October a year ago.

And, I'll introduce Joe now to the audience to moderate the program. We certainly are pleased that you're all here for the session this morning.

DR. JOSEPH E. JOHNSON [Professor and Chairman, Department of Medicine, Bowman Gray School of Medicine]:

Well, we're pleased to be able to join you this morning and to present a program on what we think is a very important topic.

Now, the Department of Medicine at Bowman Gray, as he told you, is in the process of growth and development.

We will have added about 35 per cent more faculty members as of this summer and in the last year approximately and we are growing in addition beyond that with a number of other people that we are in the process of recruiting.

The house staff has essentially doubled in size now and we have a fairly active and highly competitive staff training program now and fellowship training program.

The Department of Medicine is now sectionalized formally with each of the sub-specialty sections being formally constituted as a section so that all of these things we think are indicative and supportive of the growth and development of the department and of the institution.

I think we're very much conscious of our triple role in medicine and in the institution, in teaching of course, our students and house staff, and in the new programs that we're developing in primary care, for example, in conjunction with pediatrics and the new Department of Family Practice and in the role of continuing education and, of course our role in research, which we're pleased to say is progressing with such counter-current phenomena as a recent funding of a large program project grant in lung disease being somewhat against the trend of the federal subsidies at the moment.

Our cancer center is in the process of further growing and enlarging and as a referral center we are extremely conscious of the importance of filling our role as a referral center and in further improving and maintaining better communications with the referring physicians.

We are certainly conscious of the fact that this is an area, particularly in the area of house staff trainees and students sometimes falls down and we are working very hard to maintain our communications with all of our referring physicians on whom we are extremely dependent and with whom we hope to work more and more closely in the future.

Now, my talk this morning as you see is billed as an "Introduction" and I was preceded by the Dean who told you what's going on that's new and I'm going to be succeeded by one of our faculty members who's going to give you an "Overview of the Subject of Hypertension," so it was not absolutely clear what I was supposed to do.

[Laughter]

So, I'm not going to speak on hypertension. Rather, we've marshalled the strength of our department to cover this very important subject for you.

Hypertension is the most common condition seen in adults today probably in that perhaps 15 to 20 per cent of the adult population is said to have hypertension at the present time.

However, whatever the precise statistical position it is an extremely common and important disease and one which is incredibly treatable in many of its forms.

For that reason, it is clear to us it's one that needs to be widely appreciated by physicians of all kinds whatever their areas of interest.

It is a disease that has a lot for everybody in it in the sense that it involves the heart, kidneys, the brain. It involves in one way or another the endocrine system, the cardiovascular system. It gets involved throughout the body in producing manifestations of diseases.

So the theme of our program this morning is to survey the areas in which hypertension gets involved in the body and in producing disease.

Accordingly, we want to start with an overview of the subject and we are pleased that the first speaker will be Dr. Robert Headley.

Dr. Headley is a long standing member of our de-

partment of medicine at Bowman Gray, having come from Maryland where he got his B.S. degree and subsequently his M.D. degree and was AOA student leader in those days.

He trained at the University of Virginia in Charlottesville and subsequently took training at Bowman Gray in Cardiology and has been with us ever since.

He has progressively succeeded to positions of increasing importance including Directorship of the Out-Patient Department and subsequently is in charge of the coronary care unit and most recently, in addition to being promoted to full professor, he is also associate to the chief of professional services for the Baptist Hospital.

DR. ROBERT N. HEADLEY [Professor of Medicine, Department of Medicine, Bowman Gray School of Medicine.]:

[Whereupon Dr. Headley presented his paper which will be submitted to the *North Carolina Medical Journal* for possible publication.]

MODERATOR: Our next speaker is Dr. John Edmonds. He is a graduate of Gastonia High and Wake Forest University and of the Bowman Gray School of Medicine and did his training, part of it at Wayne County General Hospital up in Michigan but then came back to Bowman Gray by way of Georgia.

He finally came back to the faculty of Bowman Gray where he is Professor of Medicine and among other things, runs the heart station and is the resident EKG expert.

With that preamble, I'd like to introduce Dr. Edmonds who is going to talk about "Hypertension and the Heart."

DR. JOHN H. EDMONDS, Jr. [Professor of Medicine, Bowman Gray School of Medicine]:

[Whereupon Dr. Edmonds presented his paper which will be submitted to the *North Carolina Medical Journal* for possible publication.]

MODERATOR: It's always good to have a versatile dean and at this point the dean is going to take off his hat as dean and talk from the point of the view of the neurologist.

DR. RICHARD JANEWAY [Dean, Bowman Gray School of Medicine]:

[Whereupon Dr. Janeway presented his paper which will be submitted to the *North Carolina Medical Journal* for possible publication.]

MODERATOR: Well, we will now proceed having a look at the more interesting and newer developments in hypertension and then follow that with consideration of treatment, which is after all, an extremely important part of the whole process.

Our next speaker is Dr. Vardaman Buckalew who is Professor of Medicine at Bowman Gray and he, although coming from Mobile, Alabama, I think originally, managed to get up to Chapel Hill where he took his undergraduate training and then went on up to what Dr. Ward referred to as THE university in Pennsylvania, the one in Philadelphia there, and took his training—a good bit of his training subsequently at that institution, finally going to Emory, the university in Atlanta, from whence last year he joined us and is now taking a leading role in the development of our nephrology section at Bowman Gray.

Dr. Buckalew is going to talk about "Renin, Aldosterone and the Kidney."

DR. VARDAMAN BUCKALEW [Professor of Medicine, Bowman Gray School of Medicine]:

[Whereupon Dr. Buckalew presented his paper which will be submitted to the *North Carolina Medical Journal* for possible publication.]

MODERATOR: Our next speaker is Dr. John Kaufmann who is Assistant Professor of Medicine and Pharmacology at Bowman Gray.

He is a Wake Forest graduate and a Bowman Gray graduate as well and also managed to get up to the hospital in Pennsylvania for part of his training and came back to Bowman Gray and subsequently got a Ph.D. in addition to his M.D., this Ph.D. is in pharmacology, also did work at Vanderbilt in clinical pharmacology and now heads our Clinical Pharmacology Unit in the Department of Medicine.

Dr. Kaufmann is going to talk about "Pheochromocytoma."

DR. JOHN S. KAUFMANN [Assistant Professor of Medicine and Pharmacology, Bowman Gray School of Medicine]:

[Whereupon Dr. Kaufmann presented his paper which will be submitted to the *North Carolina Medical Journal* for possible publication.]

MODERATOR: The final speaker on our program this morning is Dr. John Felts, who began his undergraduate education in South Carolina and then came to Bowman Gray where for a number of years he has pioneered in the establishment of the discipline of nephrology in our institution.

Dr. Felts is Professor of Medicine and he will address himself at this time to the "Therapy of Hypertension."

DR. JOHN H. FELTS [Professor of Medicine, Bowman Gray School of Medicine]:

[Whereupon Dr. Felts presented his paper which will be submitted to the *North Carolina Medical Journal* for possible publication.]

CHAIRMAN WARD: I'd like to thank each one of the staff of the Medical Department of the Bowman Gray School of Medicine, all six, for their fine presentations this morning.

We want to thank Dr. Ken Cosgrove and his committee on the general sessions program for their change in format and for the innovation they have used this year in the surgical and medical sessions. He also reminded me to remind you that each of the sessions

will give you five hours credit so please don't forget that, those of you who are interested in continuing medical education.

At this time, it gives me great pleasure to introduce to you the President of our Medical Society, Dr. George G. Gilbert.

Dr. Gilbert was born in Massachusetts, went to public school in New Jersey, attained a B.S. degree at Kenyon College in Ohio and an M.D. degree from Johns Hopkins.

After graduating, he had one year of internship in urology at Hopkins and he came to Duke University for internship in pathology and a residency in urology. Following this, he had active duty in the naval reserve in World War II.

He came to North Carolina to practice in 1946, established his practice in Asheville and has been in the practice of private urology in Asheville since then.

He has been President of the Carolina Urological Association and the North Carolina Association of Professions.

They have two sons, both living in Western North Carolina and working with the Carolina Caribbean Corporation. Mrs. Gilbert sustained a fracture of the hip three weeks ago, but is here at this meeting with her husband and following last night's discussion with Dr. Reckless, I'm sure he would be pleased to see such devotion.

It is my pleasure to present to you your President, Dr. George G. Gilbert!

[Whereupon the entire assemblage then accorded President Gilbert a standing ovation.]

PRESIDENT GILBERT: I want to thank all of you that have the courage to stay here. Most of you have heard me so many times you can almost anticipate what I'm going to say, I'm sure.

Mr. Vice President, Members of the Society and Guests:

[Whereupon President Gilbert then read his prepared address entitled "The President's Address: Where We Stand" which was published in the *North Carolina Medical Journal*, July 1974, Vol. 35, No. 7, page 405. Following Dr. Gilbert's address he was again accorded a standing ovation.]

CHAIRMAN WARD: Thank you, Dr. Gilbert, for that excellent presentation and also in behalf of the Society, for a most fruitful and rewarding year.

At this time, this concludes our morning session.

[The meeting adjourned at twelve-thirty o'clock.]

WEDNESDAY MORNING SESSION

May 22, 1974

The Third General Session of the 120th Annual Meeting of the North Carolina Medical Society convened at nine-ten o'clock. Dr. George G. Gilbert, Immediate Past President of the Medical Society, presiding.

CHAIRMAN GILBERT: I guess we might as well get started.

Every one of our previous sessions has been a success as far as crowds go and I do want to thank the few of you who are here for coming.

I really do wish there were more here, just because the Medical Society's association with this gentleman

on my right and we are mutually proud of the interdigitation between the State Medical Society and the now called Division of Health Services and of course I'm speaking of Jake Koomen.

So, here he is!

[Whereupon Dr. Jacob Koomen, Director, North Carolina Division of Health Services, Department of Human Resources, presented his prepared annual address to the Medical Society which will be submitted to the *North Carolina Medical Journal* for possible publication.]

CHAIRMAN GILBERT: I just told our two famous speakers that here is the highlight of our whole meeting. I have looked forward for a long time to this moment, and it's a real privilege to be in the position of being on the same podium with them.

I started admiring Ed Annis way back yonder and I'm sure most of you are aware of his fabulous contributions to American medicine.

I am going to recall in introducing him however one meeting, the only meeting, although I've heard him speak many times, that was small enough, sort of like this, where you could have a real viable question and answer period where there weren't thousands of people to hear him speak and I don't know whether he will remember this or not, but it was a small MedPac meeting that was held in Boone, North Carolina, I don't know how many years ago, but as far as political progress goes, this was before Robert Kennedy was assassinated and among others who appeared with Dr. Annis, was Senator Sam Ervin. He was on the program. He wasn't quite as well known in those days.

Anyway, this was the first chance that I had had to really quiz Dr. Annis and I was as I am still periodically discouraged about the future of the practice of medicine.

I have heard him go all over the country, on television and everywhere else in our battle against Medicare and he was indeed our best spokesman in this regard.

But we had lost and we had been told ever since the days of Harry Truman and compulsory health insurance that once the government got the foot in the door, we'd had it and in many respects this is true.

However, the thing that surprised me in Dr. Annis's major speech at that meeting was that he was still optimistic and so I asked him how come?

We've had it! They've got us!

And, he said, "Well," and this may sound and they were at the time corny answers, but he said, "Everywhere I go in this country, I talk to people—cab drivers, airline stewardesses, plumbers, whoever and, first of all, I think they're wonderful people and, secondly I think they like their doctors and they are our tremendous bulwark of basic strength, right down at the grassroots for our system of medicine!"

The second thing he said, and I don't know what the percentages are today, that over 80 per cent of the doctors of this country were in private practice and he gave the opinion that he didn't think the American doctors would stand still to let the government take over.

So, with that introduction, here is Dr. Annis!

DR. EDWARD R. ANNIS [Physicians Planning Service Corporation, New York, New York; Past President of the American Medical Association]: To begin with, my optimism is just as great today as it was ten years ago.

It hadn't occurred to me why that's the case, why have encouraged two of my sons who are now doctors, a third who's on the way to continue with the practice of medicine.

[Whereupon Dr. Annis presented his address which will be submitted to the *North Carolina Medical Journal* for possible publication.]

CHAIRMAN GILBERT: If there are any of you here who have never heard Dr. Annis before, I'm sure you

will see why he's one of the great leaders of our medical generation.

I have waited a long time also to introduce Russ Roth to you, and there are many, many anecdotes I could tell you that would be embarrassing to him and he could tell many that would be embarrassing to me.

Just like beginning this morning with Jake Koomen and with Dr. Annis, Dr. Roth doesn't need any introduction otherwise, so with that I'll let him take the podium.

[Whereupon the entire assemblage then accorded Dr. Roth a standing ovation.]

DR. RUSSELL B. ROTH [President, American Medical Association]: I think there's something worth mentioning as the two of us stand here at this podium before you.

Obviously, while George and I were together at Johns Hopkins, there was something in the drinking water at our fraternity house. We didn't use a lot of it, but it must have been effective because in our small group, in this one fraternity house, at one time living there, we had Tom Ballantine, Chief of Neurosurgery at Massachusetts General and immediate past president of the Massachusetts Medical Society; Freddie Webber, recent past president of the Connecticut Medical Society; Bob Derbyshire who was sort of congenital secretary and president of the Federation of State Boards of Medical Licensure; Freddie Merchant who was the congenital treasurer for that organization; Russ Nelson who became president of the American Hospital Association among many other things; Bill Longmire, past president of the American College of Surgeons; John Atwater, a perennial delegate to the AMA from Georgia; George Gilbert and myself.

I don't know how you account for it but it seems to me that it was an extraordinary variation on the theme when one considers that in our day of medical school none of us were very much concerned with the socio-economics of medicine and few of us knew that the AMA existed or that the Medical faculty of Maryland was our locally active state agency.

[Whereupon Dr. Roth presented his address which will be submitted to the *North Carolina Medical Journal* for possible publication.]

[Whereupon the entire assemblage then accorded President Roth a standing ovation.]

CHAIRMAN GILBERT: I'm sure that all of you would agree that these are two highlights of our meeting, these two speeches, and in a way I have seen this program and felt a little sorry for my successor, Frank Reynolds, because you talk about two tough acts to follow, he really is in that spot.

Frank R. Reynolds was born in Wilmington in 1920. He's a graduate of the University of North Carolina and got his M.D. at the University of Pennsylvania, his internship at the Medical College of Virginia and residency, Children's Hospital in Philadelphia.

You know he practices pediatrics in Wilmington, so that he has been around North Carolina most of the time.

He was in the army from 1946 to 1948 and certified by the American Board of Pediatrics.

He has been through a number of offices in our association, has done a whale of a lot of very valuable work for us and highly deserves the position as President of our Society.

So, with that, I present your new President, Dr. Frank R. Reynolds.

[Whereupon as President Reynolds came up to the podium, the entire assemblage accorded him a standing ovation.]

PRESIDENT REYNOLDS: I don't know how many of you were able to stay up late enough last month to watch the Emmy Awards, but if you remember, different celebrities presented different categories of excellence and one of the celebrities was Elizabeth Taylor and she was walking up onto the stage, and as she was walking up to the stage about that time a streaker went across the stage and of course after the uproar died down, she got up to the stage and her comment was the

same thing that I'm going to say, "That's a hell of an act to have to follow!"

[Laughter]

Dr. Roth, Dr. Annis, Dr. Marden, Members of the North Carolina Medical Society, Auxiliary Members, Guests and Friends:

[Whereupon President Reynolds then presented his prepared address which was printed in the *North Carolina Medical Journal* Vol. 35, No. 8, August 1974, page 469. Following his address, he was accorded a standing ovation.]

CHAIRMAN GILBERT: To continue the nautical image that Frank made, I'm sure you can see we've got a whale of a captain for our ship for this coming year!

The meeting adjourned at eleven-thirty, o'clock.

MEDICAL AWARDS

Moore County Medical Society Medal

In 1927 the Moore County Medical Society established a fund, the interest from which is used to pay for a medal to be given for the best paper read at the State Society meeting each year. No one is eligible to receive this medal except Fellows of the Medical Society of the State of North Carolina in good standing; no invited guest is allowed to complete.

Each Section Chairman selected a committee of three to decide on the best paper in their section. The winning papers are then turned over to the State Committee, who select the one to receive the medal. The following award was made:

1971—Herbert J. Procter, M.D., Chapel Hill
"POST TRAUMATIC PULMONARY INSUFFICIENCY"
(Section on Surgery, May 17, 1971)

1972—Donald C. Mullen, M.D., Charlotte
"CURRENT CONCEPTS IN THE MANAGEMENT OF ABDOMINAL AORTIC ANEURYSMS."
(Section on Surgery, May 23, 1972)

1973—Susan C. Dees, M.D., Durham
"THE ROLE OF GASTRO-ESOPHAGEAL REFLUX IN NOCTURNAL ASTHMA IN CHILDREN"
(Section on Pediatrics, May 22, 1973, Pinehurst)

The George Marion Cooper Award

The Fellows of the Wake County Medical Society present the George Marion Cooper Award established in honor of George Marion Cooper, physician and health benefactor.

The medal is awarded by the Fellows of the Wake County Medical Society as a token of appreciation and esteem in recognition of the eminence of an essay contributing to the knowledge and advancement of the science of medicine in the field of Preventive Medicine, Public Health, or Maternal and Infant Health Care, presented before the Medical Society of the State of North Carolina. The following award was made:

1971—Takey Crist, M.D., Chapel Hill
"ABORTION—WHERE HAVE WE BEEN?
WHERE ARE WE GOING?"
(Section on General Practice of Medicine, May 18, 1971)

1972—John L. McCain, M.D., Wilson
"TRAIN YOUR OWN ASSISTANT"
(Section on Internal Medicine, May 23, 1972)

1973—Elizabeth Kanof, M.D., Raleigh
"SKIN CANCER — EDUCATION AND DETECTION AT A STATE FAIR"
(Section on Dermatology—May 20, 1973, Pinehurst)

HISTORICAL DATA

In the interest of economy the lengthy Historical Data printed in the Transactions will only be printed every five years. Only the information relating to recent years is included here.

Should any member desire additional Historical Data, he

may request the information for earlier years from the Medical Society Headquarters Office at 222 North Person Street, (Mail address: P. O. Box 27167) Raleigh, North Carolina 27611.

HISTORY OF THE NORTH CAROLINA MEDICAL SOCIETY ANNUAL MEETINGS

Date	Place of Meeting	Number in Attendance	President	President-Elect	Vice Presidents	Sec.-Treas.	Members on Roll	Honorary Members	Life Members
1945	No meeting because of O.D.T. restrictions		Paul F. Whitaker	Oren Moore	Wm. H. Smith Zack D. Owens	Roscoe D. McMillan	1,811	7	383
92 1946	Pinehurst	889	†Oren Moore		†Wm. H. Smith Zack D. Owens	Roscoe D. McMillan	1,939	6	397
93 1947	Virginia Beach, Va.	444	†Wm. M. Coppridge	Frank A. Sharpe	G. E. Bell J. B. Bullitt	Roscoe D. McMillan	2,191	7	404
94 1948	Pinehurst	920	†Frank A. Sharpe(†)	James F. Robertson	V. K. Hart J. G. Raby	Roscoe D. McMillan	2,298	8	407
95 1949	Pinehurst	998	James F. Robertson	G. Westbrook Murphy	Joseph J. Combs Joseph A. Elliott	Roscoe D. McMillan	2,318	5	405
96 1950	Pinehurst	947	†G. Westbrook Murphy	Roscoe D. McMillan	Ben F. Royal Joseph A. Elliott	Millard D. Hill	2,283	5	455
97 1951	Pinehurst	938	Roscoe D. McMillan	Frederic C. Hubbard	Joseph A. Elliot Henderson Irwin	Millard D. Hill	2,341	5	469
98 1952	Pinehurst	969	Frederic C. Hubbard	J. Street Brewer	Forest M. Houser Arthur Daughtridge	Millard D. Hill	2,326	5	476
99 1953	Pinehurst	1,016	J. Street Brewer	Joseph A. Elliott	George W. Paschal John R. Bender	Millard D. Hill	2,673	5	486
00 1954	Pinehurst	1,077	†Joseph A. Elliott	Zack D. Owens	John F. Foster Julian A. Moore	Millard D. Hill	2,801	6	486
01 1955	Pinehurst	991	Zack D. Owens	J. P. Rousseau	George W. Paschal, Jr. Elias S. Faison	Millard D. Hill	2,896	6	507
02 1956	Pinehurst	1,022	†James P. Rousseau	Donald B. Koonce	E. W. Schoenheit Milton S. Clark	Millard D. Hill	3,058	7	561
03 1957	Asheville	867	Donald B. Koonce	Edward W. Schoenheit	John S. Rhodes O. Norris Smith	Millard D. Hill	3,127	8	522
04 1958	Asheville	781	Edw. W. Schoenheit	Lenox D. Baker	George W. Holmes Amos N. Johnson	Millard D. Hill	3,171	9	542
05 1959	Asheville	651	Lenox D. Baker	John C. Reece	Amos N. Johnson Kenneth B. Geddie	John S. Rhodes	3,211	10	251
06 1960	Raleigh	848	John C. Reece	Amos N. Johnson	Chas. M. Norfleet, Jr. W. Walton Kitchin	John S. Rhodes	3,247	12	472
07 1961	Asheville	636	Amos N. Johnson	Claude B. Squires	Theodore S. Raiford Charles T. Wilkinson	John S. Rhodes	3,248	12	438
08 1962	Raleigh	745	†Claude B. Squires	John R. Kernodle	John A. Payne, III J. Sam Holbrook	John S. Rhodes	3,339	9	425
09 1963	Asheville	714	John R. Kernodle	John S. Rhodes	H. Fleming Fuller Jacob H. Shuford	Charles W. Styron	3,491	9	431
10 1964	Greensboro	677	John S. Rhodes	T. S. Raiford	Wm. F. Hollister F. G. Patterson	Charles W. Styron	3,473	8	398
11 1965	Charlotte	738	†T. S. Raiford	George W. Paschal, Jr.	Hubert McN. Poteat Wayne J. Benton	Charles W. Styron	3,516	8	390
12 1966	Asheville	545	George W. Paschal, Jr.	Frank W. Jones	W. Otis Duck John L. McCain	Charles W. Styron	3,597	12	339
13 1967	Pinehurst	644	†Frank W. Jones	Robert A. Ross	David G. Welton Daniel A. McLaurin	Charles W. Styron	3,606	14	302
14 1968	Pinehurst	623	Robert A. Ross	David G. Welton	E. T. Beddingfield, Jr. James S. Raper	Charles W. Styron	3,642	13	298
15 1969	Pinehurst	577	David G. Welton	Edgar T. Beddingfield, Jr.	John Glasson Mark McD. Lindsey	Charles W. Styron	3,674	13	298
16 1970	Pinehurst	580	Edgar T. Beddingfield, Jr.	Louis deS. Shaffner	Robert P. Crouch Rose Pully	Charles W. Styron	3,711	14	289
17 1971	Pinehurst	575	Louis deS. Shaffner	Charles W. Styron	George G. Gilbert James G. Jones	E. Harvey Estes, Jr.	3,765	14	287
18 1972	Pinehurst	543	Charles W. Styron	John Glasson	Kenneth E. Cosgrove William H. Romm	E. Harvey Estes, Jr.	4,059	15	267
19 1973	Pinehurst	562	John Glasson	George G. Gilbert	Frank R. Reynolds Harry R. Summerlin	E. Harvey Estes, Jr.	4,123	15	278
20 1974	Pinehurst	623	George G. Gilbert	Frank R. Reynolds	*Michael F. Keleher †D. E. Ward, Jr.	E. Harvey Estes, Jr.	4,294	15	283

Deceased.

†Died during term of office; succeeded by James F. Robertson, president-elect.

*Resigned as First Vice-President.

†Became First Vice-President at resignation of Dr. Keleher.

ROSTER OF MEMBERS OF COMMISSION FOR HEALTH SERVICES
(Formerly State Board of Health)

Name	Address	Appointed by	Term
James S. Raper, M.D.	Asheville	Medical Society	1967 to 1971
Paul F. Maness, M.D.	Burlington	Medical Society	1967 to 1971
Ben W. Dawsey, D.V.M.	Gastonia	Gov. Dan Moore	1967 to 1971
Ernest A. Randleman, Jr., PhG.	Mount Airy	Gov. Dan Moore	1967 to 1971
Joseph S. Hiatt, Jr., M.D.	Southern Pines	Medical Society	1969 to 1973
Jesse H. Meredith, M.D.	Winston-Salem	Medical Society	1969 to 1973
Lenox D. Baker, M.D. (1)	Durham	Gov. Robert W. Scott	1969 to 1973
J. M. Lackey	Hiddenite	Gov. Robert W. Scott	1969 to 1973
Charles Barker, D.D.S.	New Bern	Gov. Robert W. Scott	1969 to 1973
Ralph W. Coonrad, M.D. (2)	Durham	Gov. Robert W. Scott	1971 to 1973
James S. Raper, M.D.	Asheville	Medical Society	1971 to 1975
Paul F. Maness, M.D.	Burlington	Medical Society	1971 to 1975
Ernest R. Randleman, Jr., PhG.	Mount Airy	Governor Robert W. Scott	1971 to 1975
Donald W. Lackey, D.V.M.	Lenoir	Governor Robert W. Scott	1971 to 1975
Jesse H. Meredith, M.D.	Winston-Salem	Medical Society	1973 to 1977
Maurice A. Kemp, M.D.	Charlotte	Medical Society	1973 to 1977
Richard T. Belton, D.D.S.	Gastonia	Gov. James E. Holshouser, Jr.	1973 to 1977
Faye B. Eagles, D.C.	Rocky Mount	Gov. James E. Holshouser, Jr.	1973 to 1977
Grady Hunter	Boonville	Gov. James E. Holshouser, Jr.	1973 to 1977
Buford W. Kidd, O.D.	Greensboro	Gov. James E. Holshouser, Jr.	1973 to 1977
Clyde W. Kiker	Greensboro	Gov. James E. Holshouser, Jr.	1973 to 1977

(1) Resigned when appointed Secretary, Department of Human Resources.

(2) Fill unexpired term Dr. Baker.

ROSTER OF MEMBERS OF BOARDS OF MEDICAL EXAMINERS

Name	Address	Term
Bryant L. Galuska, M.D., President	Charlotte	1968 to 1974
Charles B. Wilkerson, Jr., M.D., Secretary	Raleigh	1972 to 1978
Frank Edmondson, Jr., M.D.	Asheboro	1970 to 1976
Joseph W. Hooper, Jr., M.D.	Wilmington	1968 to 1974
Cornelius T. Partrick, M.D.	Washington	1968 to 1974
E. Wilson Staub, M.D.	Pinehurst	1972 to 1978
Vernon W. Taylor, Jr., M.D.	Elkin	1970 to 1976
*Joseph J. Combs, M.D., Executive Secretary	Raleigh	
David S. Citron, M.D.	Charlotte	1974 to 1978
James Jerome Pence, M.D.	Wilmington	1974 to 1978
Jack Powell, M.D.	Asheville	1974 to 1978
Bryant D. Paris, Jr., Executive Secretary	Raleigh	1973 to

* Retired October 31, 1973





